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Supervisor: Dr Hannah Heath

Issues, response and support needs of parents if their child had self-harmed, from a parents and professionals perspective

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Declaration

“This work is original and has not been submitted in relation to any other degree or qualification”

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Acknowledgements

I would like to thank my supervisor Hannah Heath for her guidance and support with carrying out my research and writing of my dissertation. Thank you to my colleagues at work who have supported to me carry out this research and also thank you to my family.

University of Chester

Department of Psychology

Research Module Meeting Log 2017/2018

NAME: Samantha Ruck

SUPERVISOR: Hannah Heath

Date Discussion topics

Date	Discussion topic
15th November 2017 – 2:20pm	Initial meeting to discuss the possibility of carrying out research project on self-harm, and possible focus of this research being on parents
22nd November 2017 – 2:30pm	Further discussion around possible research project, and developed of an individual research project proposal.
29th November 2017 – 2:40pm	Discussion around final changes to research proposal before submission by 5pm that day. Discussion around requirements for ethical approval
13th December 2017 – 2:40pm	Discussion regarding ethical approval and research design

17th January 2018 – 2:30pm	Discussion regarding the development of interview and focus group questions
24th January 2018 – 11am	Hannah signing off ethical approval for submission to The University of Chester Psychology Ethics Community
7th February 2018 – 11am	Discussion of planning interviews
28th February 2018 – 11am	Reviewing feedback from ethical approval and submission of Application for Ethical Approval Amendment Form, with requested changes
	Discussion and planning of recruitment of professional via local charity and parents via Chester University RPS system
21st March 2018 – 3pm	Discussion around sluggish recruitment of parents via the PRS, submission of Application for Ethical Approval Amendment Form for boarder advertising for parents
25th April 2018 – 2:40pm	Discussion of progress with interviews
30th May 2018 – 11:30am	Discussion around writing up of draft introduction and method section
25th July 2018 – 11am	Review of where research project was at. Discussion around ontological perspective and epistemological position.
	Initial discussion around themes appearing from transcribing of data
17th August 2018 – 10am	Further discussion around ontological perspective and epistemological position.
	Discussion of initial analysis of parent interviews
	Discussion around research questions
22nd August 2018 – 2pm	Discussion over the phone to refine research questions as part of write up of dissertation

29th August 2018 – 11am	Discussion around result found from analysis of interview and starting to write up the results section. Discuss of how explain the multi-methods process in the methods section.
5th September 2018 – 10am	Discussion over the phone about parents result section, and reflection within methods section.
17th September 2018 – 12pm	Discussion on integration section and process of pulling together the finding from the two research programme.
19th September 2018 – 11am	Phone discussion on discussion outline
26th September – 5:30pm	Discussion over the phone regarding introduction and discussion section
3rd October – 9am	Discussion over the phone regarding final editing

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Abstract

Self-harm for young people has been considered to be a significant health concern (Byrne et al., 2008) and is understood to be typical amongst young people (Hawton et al., 2002). Parents experience an array of overwhelming emotions on finding out about their child's self-harm (Raphael et al., 2006). To date, little attention has been paid to exploring the understanding and experiences of parents whose children have not self-harmed or looking at the role of mental health (MH) professionals supporting parents from the professional view point. The aim of this research was to understand from both a parents and professionals perspective, what the perceived issues for parents are if their child self-harmed; how would/do parents respond to self-harm; and what support needs do the parents have. A multiple qualitative perspectives design was used. Seven parents were interviewed, alongside two focus groups and one interview with six Mental Health (MH) Professionals and were analysed with Thematic Analysis (Braun & Clarke, 2006). The results indicated that parents had a perceived lack of knowledge about self-harm and available support services. How parents respond to a child's self-harm is influenced by their lack of understanding, how they find out and their natural desire to protect their child. Education about self-harm, strategies for parents and peer support group were identified as key mechanisms for professionals to provide support to parents. Parents and professionals both highlighted the lack of knowledge parents have about self-harm and their desire for support to help their child. There is a future research need to explore the processes which parents follow to seek information and help regarding self-harm and the impact of parent peer support in both community and clinical settings.

Introduction

1.1 The nature of self-harm

Self-harm has been considered to be a significant public health concern (Byrne et al., 2008; Crowell, Beauchaine, McCauley, Smith, Vasilev & Stevens, 2008; Doyle, Treacy, & Sheridan, 2015; Raphael, Clarke, & Kumar, 2006; Glazebrook, Townsend, & Sayal, 2015), receiving increased attention in many countries in the West with regard to developing more effective professional treatment and help (Madge et al., 2008). Nock (2009) defined self-harm as a person's intentional destruction of their own body tissue, as a coping strategy, without suicidal intent. Others consider self-harm to be any form of intended self-injury, including self-poisoning which does not have a fatal outcome, regardless of intent (Glazebrook et al., 2015; Hughes et al,. 2017). It has also been argued that self-harm can be viewed on a continuum of behaviours with non-suicidal self-injury at one end and completed suicide at the other (Brausch & Gutierrez, 2010). In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) self-harm has been defined as a disorder in its own right; 'Non-Suicidal Self-Injury' (NSSI) (APA, 2013), where there is no suicidal intent. The DSM-V definition, however, is limited in its focus by including only actions which are carried out directly on the skin (such as cutting, hitting, and burning) and does not include self-poisoning or overdose (APA, 2013). Hawton, Rodham, Evans & Weatherall (2002) definition is broader, including non-suicidal self-poisoning and overdose. Their definition focuses on the motivation for the self-harm act, rather than the method. For the purposes of this research the Hawton et al. (2002) definition of self-harm was used because of the breadth and its focus on motivation rather than behaviours.

Self-harm is understood to be typical amongst adolescents, with the average age when young people start self-harming being between 12 to 14 years (Jacobson & Gould, 2007, as cited in Kelada, Hasking & Melvin, 2016). Community studies report that 10% to 15% of young people

have, at some point, self-harmed (Doyle et al., 2015; Hawton et al., 2002). However, the accurate picture of the number of young people self-harming is not known, as many young people do not tell anyone about their self-harm (Arbuthnott, & Lewis, 2015).

1.2 How the understanding of self-harm has changed

The understanding of self-harm has altered over the last 20 years. Pre-1960, self-harm was conceptualised as a failed suicide attempt (Alder & Alder, 2005; Skegg, 2005). However, in the 1960s the number of people admitted to hospital for attempted suicide increased and alongside this came the understanding that a sizeable proportion of these people did not intend to kill themselves (Skegg, 2005). Much of the early research on self-harm was focused on those who had been admitted to hospital because they were considered to have a severe mental illness (Skegg, 2005). Alder and Alder (2005) claimed that until 1990 there was little public knowledge of self-harm and, therefore, people who self-harmed did this in a "social vacuum" (p. 351). They argued that around 1996 the awareness of self-harm grew when it started to appear in the media and a number of celebrities openly talked about their own self-harm. Awareness increased further around 2001-2002 with the rise of the internet and, specifically, of websites on the subject where people who self-harmed could chat to others who were self-harming (Alder & Alder, 2005). Awareness grew that many people used self-harm to alleviate negative feelings. (Alder & Alder, 2005).

Since the early 2000s research has looked further into a range of factors which can explain in more detail why young people self-harm. Research has shown that self-harm is used for a range of reasons including, to help with regulation of emotions, as self-punishment (Klonsky, 2009; Hughes et al., 2017), and to call for help from others (Scoliers et al., 2009; Hughes et al., 2017). The three most commonly stated reasons, in a community based study of 978

adolescents, explaining their motivation for their most recent self-harm episode were ‘To get relief from a terrible state of mind’, because they wanted ‘to die’ and because they wanted ‘to punish myself’ (Rasmussen, Hawton, Philpott-Morgan & O'Connor, 2016, p. 179). The influence of friends was not cited as a motivation within the Rasmussen et al. (2016) study for why young people self-harm, however other studies have found peers’ self-harm behaviour to influence individuals own self-harm (Rissanen, Kylma & Laukkanen, 2009; Prinstein et al., 2010). Young people who self-harm are more likely to know of peers who have self-harmed or have experience of self-harming by family members (Hawton et al., 2002; Quigley, Rasmussen & McAlaney, 2017), showing there are multiple factors which influence a young person’s decision to self-harm.

It has been argued that mental health issues have been seen to be more prevalent in those who self-harm. 63% of females in the community based study by Hintikka, Tolmunen, Rissanen, Honkalampi, Kylmä & Laukkanen (2009), were deemed to have a major depressive disorder. Depression, anxiety and eating disorders are often found to co-occur in adolescents who self-harm (Lewis & Heath, 2015). However there is limited research which looks specifically at the link between mental health and self-harm in young people.

1.3 Behaviours of young people who self-harm

Young people use a range self-harm methods cutting, scratching, head banging, bruising, burning (Lewis & Health, 2015), self-hitting, biting, self-poisoning and bone breaking (Laye-Gindhu & Schonert-Reichl, 2005). Self-harm is often repetitive (Hawton, Saunders, & O'Connor, 2012), regularly carried out in secret (Fortune, Sinclair, & Hawton, 2008; Madge et al., 2008) and most commonly the young person will carry out their self-harm at home (Madge et al., 2008).

There is incongruity within research around whether self-harm is more common in females than males (Hamza, Stewart & Willoughby, 2012). However, this could be as a result of self-harm in males being less well understood (Taylor, 2003). Taylor (2003) noted differences in the self-harm methods that females and males use. Self-cutting is more common amongst females whereas self-hitting or head banging has been more commonly observed in males (Gandhi et al., 2016; Hamza et al., 2012). Socialisation patterns can explain the difference in the type of methods females and males choose to self-harm. Females are more likely to internalise their distressing feelings whereas boys express their difficulties outwardly through their behaviour (Crick & Zahn-Waxler, 2003; Parker et al., 1998; cited in Rasmussen et al., 2016). In addition, Taylor (2003) argued that the reason why women are believed to be more likely to self-harm is because the focus within the field of self-harm research has been on women.

1.4 Disclosure of self-harm and help seeking by young people

In their school based survey of 15 and 16 year olds, Fortune et al. (2008) found the prevalence of a young person having self-harmed at some point previously to be 10.3%, and more recent school based study in Northern Ireland in 2014, found a similar prevalence of 10% (Rasmussen & Hawton, 2014). Fortune et al. (2008) study found that 40% considered their friends to be their main support network compared to 11% who named a family member. Young people who prefer to seek guidance from their friends are also often disinclined to seek help from professionals (Doyle et al., 2015). Young people did not want to tell other people about their self-harm due to believing they could cope with it on their own, worrying about what other people would think of them if they found out, and not wanting to upset or concern others (Fortune et al., 2008). A qualitative study of young people who were at that time self-harming showed that they felt many people did not understand why they self-harmed and that this was

confused with suicidal intent, and furthermore that this lack of understanding could leave them feeling even more alone (Brown, & Kimball, 2013).

Although parents were not cited as the most common point of contact for young people to seek help, they were still positioned second compared to other sources of support such as teachers, doctors and drop in support centres (Fortune et al., 2008). Raphael et al. (2006) argued that the support of parents is paramount as parents want to play a key role in their child's recovery. Arbuthnott, & Lewis (2015) found that many parents see themselves as the main support for their child, and Kelada et al. (2016) argued that parents can encourage their child to gain professional treatment. Parents are more likely to become aware of self-harm if the rate of recurrence and the level increases (Kelada et al., 2016). Many young people, however, do want to speak to others, with one study showing that 86% young people who have self-harmed reported that another person was aware of their self-harm and for 44% it was their mother (Rissanen, Kylma & Laukkanen 2006b as cited in Rissanen, Kylma & Laukkanen, 2011). This highlights that there is a willingness for young people to talk about their self-harm, potentially with a parent, and that many parents see themselves as a key source of support for their child when they self-harm.

Young people have said that when parents do find out, they either overact or try to minimise their self-harm which can make them feel as if they want to self-harm more (Rissanen et al., 2009). This can mean that they are less likely to seek further support if the parents' response has not been positive (Oldershaw, Richards, Simic & Schmidt, 2008). Parents can, however, play a key role in the young person connecting with a professional service by providing encouragement from someone they know cares for them (Rissanen et al., 2013). Several researchers have cited the crucial importance of parents in enabling effective treatment for young people who self-harm (Fortune, Cottrell, & Fife, 2016; Glenn, Franklin & Nock, 2015). Young people are more likely to access professional assistance when encouraged to do so by their parents (Arbuthnott, & Lewis, 2015) and are more likely to cease self-harming if supported by parents (Rissanen et al., 2009). For some parents their child's self-harm has

resulted in them communicating more with their child and feeling closer to them (Kelada et al., 2016). Parents respond in a range of different ways, but when they respond positively, this can have a beneficial impact on their child's treatment and access to professional services, and can also lead to an improved relationship with their child.

1.5 Parents response to young people's self-harm

Parents discover about their child's self-harm in a range of different ways. Reports of the child's self-harm can come from teachers, friends of their child or through a disclosure to a professional working with their child (Ferrey et al., 2016b). Some parents reported feeling that something was amiss (Ferrey et al., 2016a), and for a number of months running up to the disclosure, being suspicious about their child's behaviour and sometimes having spotted self-harm injury marks upon their child (Oldershaw et al., 2008). When parents had their suspicions and tried to speak to their child about it, the child made up reasons for the marks and did not confess to self-harming. Parents went on to explain that they took a 'wait and see' approach, as they were not convinced by the young person's explanation (Oldershaw et al., 2008, p.141). In other research, parents described "taking life one day at a time" (Ferrey et al., 2016, p. 5), because they were unsure how to proceed or what the outcome of their actions would be. Some parents took refuge in denial, hoping that if they ignored the self-harm it would go away. This impacted on how quickly they accessed professional support for their child (Oldershaw et al., 2008). While many studies have focussed on the impact of the discovery upon the parents and their steps following discovery, most research has stopped short of exploring how the different ways that parents find out can impact on the child's recovery process. Research is also limited around the particular experiences, understanding and knowledge-base of the parents before they discover their child is self-harming. Research has focused on parents of children who are already self-harming, and reveals a gap in research focused on parents of children who have not self-harmed.

Research indicates that parents are not fully aware of the frequency of their child's self- harm, underestimating the age their child started and the probability of them continuing (Kelada, Whitlock, Hasking and Melvin, 2016). A study exploring young people and parent dyads found that around 20% of the young people reported having a history of self-harm, but only 40% of those young people's parents reported being aware (Kelada, Whitlock, Hasking and Melvin, 2016). This highlights that many parents are not aware of their child's self-harm and hence, for many, the discovery of the self-harm comes as a shock (Raphael et al., 2006).

Upon finding out about their child's self-harm parents experience an array of overwhelming emotions, (Byrne et al,.2008; Ferrey et al., 2016; Kelada et al., 2016; McDonald, O'Brien, & Jackson, 2007; Morgan et al., 2013; Raphael et al., 2006). This discovery has been referred to as a traumatic event (Morgan et al., 2013; Raphael et al., 2006), and emotions experienced by parents included guilt that they had not known that their child was self-harming (Raphael et al., 2006), and shame that their child was experiencing such a level of distress which they were not aware of (McDonald et al., 2007). They often felt helpless, shocked and confused, believing they had let their child down or failed to protect them (Byrne et al., 2008; Morgan et al., 2013; Raphael et al., 2006) and thus believed they were inadequate parents (McDonald et al., 2007; Morgan et al., 2013). Raphael et al. (2006) likened the process to that of grief, with the initial shock sometimes being expressed as anger, which could be directed toward professionals.

Parents report not knowing how to respond to or help their child (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008). Some parents confused self-harm with a suicide attempt by their child (Rissanen et al., 2009). Parents felt that they lacked the skills they believed they needed (Kelada et al., 2016), and were concerned that they might say the wrong thing and make the situation worse (Ferrey et al., 2016). As a result, they often experienced feelings of isolation and anxiety. They felt ashamed about how others might view their situation and judge them because of the stigma they believed was linked to self-harm (Raphael et al., 2006). In the search to understand the reason for their child's self-harm, parents often blamed

themselves and felt the need to keep the knowledge of the self-harm within the family (Ferrey et al., 2016; McDonald et al., 2007; Raphael et al., 2006). Parents have spoken about the impact of the discovery of their child's self-harm leading to issues with their own mental health, including depression (Rissanen et al., 2009). This research has highlighted that parents' lack of understanding and confusion impacts on how they view their child's self-harm. This often leads them to blame themselves and feel shame, which in turn impacts on their own mental health and their response to their child. The lack of research which has focussed on parents' knowledge and understanding of self-harm prior to the discovery of their child's self-harm, prevents us from fully understanding the possible links between this and the levels of shock, emotional distress and the impact of the disclosure that parents experience.

Parents indicate that their relationship with their child changed following the discovery of self-harming (Kelada et al., 2016). Parents report becoming hyper-vigilant, checking their child and surveying their child's behaviour, such as reading diaries and messages (Ferrey et al., 2016a). Parents also felt that watching over their child too much would make the situation worse and make the child more anxious (Ferrey et al., 2016a). In the beginning, many parents tried to gain some control over their child's self-harm by removing sharp objects from the home (Byrne et al., 2008; Ferrey et al., 2016a; Kelada et al., 2016). Ferrey et al.'s (2016a) research found that the strategies deployed by parents depended on how they viewed their child's self-harm. More supportive strategies were used by parents when they understood the self-harm to be linked to their child's ill mental health. However if the self-harm was seen as intentionally bad behaviour, strategies which increased monitoring and control were used (Ferrey et al., 2016a).

Parents believed there was a lack of support services available and they lived in fear that their child would self-harm again while they waited for professional help (Byrne et al., 2008). Waiting for support led them to feel anger which was at times directed at the child who was self-harming because of the emotional distress and disruption the situation was bringing to the family (Byrne et al., 2008). Many parents sought support from professionals. However, some

were deterred by how they thought a professional would judge or view them (McDonald et al., 2007; Raphael et al., 2006).

In studies with mothers, research showed that they would shift their attention away from other roles within the family, which led to further guilt that they were not fulfilling these other roles (McDonald et al,. 2007). Parents experienced difficulties with setting boundaries and challenging their child's behaviour because they were fearful that any conflict might result in their child self-harming (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al,. 2006). Parents have used the term *walking on eggshells* to describe how they feel they have to behave with their child following the discovery of the self-harm (Ferrey et al., 2016; Oldershaw et al., 2008). This can lead to the functioning of the family unit being impaired by their child's self-harm (Kelada et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008) with some parents feeling that the child holds the power within their family (Arbuthnott, & Lewis, 2015; Ferrey et al., 2016a; Raphael et al., 2006). Parents also spoke about how disagreement between themselves about the strategies to be used to support their child could lead to conflict, with some parents feeling that their partners were not supportive, (Ferrey et al., 2016a), increasing the pressure experienced. Ferrey et al. (2016) UK based research found that some parents found themselves in financial difficulties as a result of having to work only part-time in order to have additional time to care for their child. Supporting the cost of private counselling or psychiatric services also depleted family finances (Ferrey et al., 2016b). Therefore additional pressure can arise, depending on how the individual family is able to deal with the child's self-harm.

Research by Hughes et al. (2017) suggested that over time parents become less overwhelmed by their feelings when they begin to understand their child's problems, and make sense of their child's difficulties. In order to come to this understanding, parents reported seeking out information, often starting with searching on the internet with the strong desire to ensure that sources were legitimate; and speaking to other parents, to professionals and to their child (Hughes et al, 2017). Research into the specific process or strategies that parents follow after

discovering their child's self-harm in order to search for information or help is limited. A number of studies do however detail that parents feel there is a lack of information and support for parents of children who self-harm (Byrne et al., 2008; Ferrey et al., 2016b; Raphael et al., 2006).

1.6 Importance of professionals

Research has shown that parents attempt to seek support from professionals in order to gain legitimate knowledge and understanding of their child's self-harm (Hughes et al, 2017), and they had welcomed support because they had felt unprepared to support their child alone following their child self-harming (Stewart et al., 2016). However there is a lack of research within the field of self-harm literature which looks specifically at how parents seek help and the prevalence of parents who go on to seek help from professionals.

Research has shown that the support parents have received from professionals has not always been perceived as helpful. Reports have highlighted parents' negative experiences where they have felt that the professional blames them for the child's self-harm and have felt disrespected (Lindgren, Aström, Graneheim, Umeå, Institutionen för, & Medicinska, 2010; Raphael et al,. 2006). Parents have felt that professionals have been insensitive towards their feelings and the lack of support can lead to increased anxiety and the sense of helplessness they feel regarding their child's self-harm (Raphael et al,. 2006). Raphael et al.'s (2006) research with parents of children over the age of 16 who had attended hospital as a result of taking an overdose of paracetamol reported that these feelings are intensified by a lack of understanding from the professionals working with their child. The authors cited as a possible barrier the parents' emotional state at the time when their child was in hospital and their perception of how the professionals would respond. When the professionals' initial response

to parents has been considered poor by the parents, it has discouraged or prevented them from seeking help from professionals in the future (Arbuthnott, & Lewis, 2015).

The importance of the way that professionals support parents has been emphasised in the literature on young people who self-harm. The right attitude of professionals towards parents is essential to the quality of the parent experience (Raphael et al,. 2006; Stewart et al., 2016). The role of professionals is to listen to parents, provide an understanding of the wide range of issues which can lead to a child self-harming (Hughes et al., 2017) and to support parents to manage their own anxiety (McDonald et al., 2007). McDonald et al. (2007) argued for the importance of professionals working with parents of children who self-harmed to normalise the feelings of shame or guilt that the parent might be experiencing. They discussed the benefits of providing parents with psycho-education about why young people self-harm. Researchers have argued that it is important that professionals working with the family are non-judgemental and empathetic (Kelada et al., 2016); that they work in a young person-centred way rather than the process feeling like a tick box exercise to assess risk (Stewart et al., 2016); and that training for professionals ensures they have the appropriate knowledge and skills to work with young people who have self-harmed (Rissanen et al., 2013). The research regarding the involvement of professionals is from the parents' perspective, and there is a gap within the field of self-harm research which looks at the role of the professional in supporting the parents from specifically the professionals' view point.

Parents have expressed their desire to share their experiences with other parents of self-harming children (Hughes et al, 2017), and one method requested has been through a facilitated parents' peer support group (Arbuthnott, & Lewis, 2015; Baetens et al., 2015; Ferrey et al., 2016; McDonald et al., 2007). It has been proposed that parents may find it easier to speak to peers who they don't know, but who are in a similar situation to themselves (Ferrey et al., 2016b). Groups facilitated by professionals provide parents with the space to gain social support, guidance, and share experiences with peers (Arbuthnott, & Lewis, 2015; Ferrey et al., 2016a). Programmes such as SPACE, 'Support by Parents and Carers of Young People'

who self-harm (Morgan et al., 2013) have been developed in response to this need. The SPACE programme, developed by a team of professionals working with young people who self-harmed, included psycho-educational information regarding communication, parenting skills and mental health awareness (Morgan et al., 2013). A non-control study of the SPACE programme showed a positive impact for parents, rating their degree of psychological distress as decreased, and indicating increasing levels of parental satisfaction after the intervention. The intervention appears to have a lasting impact, with the outcomes being maintained at a 6 month follow-up period (Power et al., 2009).

To summarise, parents have reported feeling unprepared to provide support to their child when they are self-harming. They have reported experiencing guilt, shame, and shock (Byrne et al,.2008; Ferrey et al., 2016; Kelada et al., 2016; McDonald et al., 2007; Morgan et al., 2013; Raphael et al., 2006). Whilst we have some insight into the experiences of parents of children who self-harm, little attention has been paid to exploring the understanding and experiences of parents whose children have not self-harmed in order to assess levels of awareness to self-harm and how they may manage their child's self-harm, and how they would seek support. Research into the knowledge-base of parents of children who are not self-harming could reveal some greater understanding of parents' general understanding of self-harm and the processes parents might follow to seek help if they were to discover their child was self-harming. Furthermore, professionals working with young people who self-harm and their parents are often overlooked, despite them having a unique insight into the issues that are facing parents. Consequently, this project intends to use a multiple methods qualitative design, in order to capture the multiple voices of parents of children who have not self-harmed, and professionals who work with children who do self-harm. This will provide an understanding of two groups that have been largely ignored in research, drawing on their experiences in order to explore key issues facing the parents of young people who may self-harm. This is in order to answer the research questions from both the parents and professionals perspective;

What are the perceived issues for parents if their child self-harmed?

How would/do parents respond to self-harm of a child?

What support needs do the parents need or want?

Methods

To date, research has established that parents of those who self-harm are a vulnerable population who are often struggle after finding that their child is self-harming. Yet little is known about the knowledge and experiences of parents of children who have not self-harmed. In addition, multiple qualitative perspectives research is limited in the context of self-harm, particularly around research concerning parents. In addition, professionals working with young people who self-harm and their parents are often overlooked as a source to gain further insight into the experiences of parents. To gain a multiple perspective view point, two different groups of participants were interviewed. Interviews were conducted with parents of children who had not self-harmed, and Mental Health (MH) professionals who work both with children who have self-harmed and their parents. These interviews were then analysed using Thematic Analysis (Braun & Clarke, 2006).

2.1 Theorising the production of knowledge and reality

It is important that when designing a research project, a researcher should clarify their ontological perspective, "asking what you see as the very nature, character and essence of things in the social world" (Mason, 2018, p. 4), and secondly their epistemological position, understanding what their theory of knowledge is (Mason, 2018). This is important because the ontological and epistemological position of a researcher determines the appropriate methodology and chosen method of research (Braun & Clarke, 2013). A researcher's ontological position can be viewed on a continuum, with a relativism view point, that reality is developed through an individual's experiences (Braun & Clarke, 2013) at one end, and a realism view point, that there is a pre-existing social reality and this can be understood through research (Braun & Clarke, 2013) at the other. A relativist ontological position has been taken by the researcher, that there are many possible realities (Braun & Clarke, 2013) and that

individuals gain an understanding of their world and their reality through their own current and past experiences which is shaped by boundaries set within their cultures (Zemach, 1989; as cited in Heath, 2016). The researcher's epistemological position is that of social constructionism; what we understand and experience is not a direct reflection of the situation, but a view which is taken through a lens, filtering an individual reading of that circumstance (Willig, 2008).

2.2 Participants

Semi-structured interviews were completed with parents of children who had not self-harmed, and semi-structured focus groups and an interview were completed with MH professionals who had worked with parents whose children had self-harmed.

2.2.1 Parents

Seven parents, two fathers and five mothers, of children aged 16 plus who had not self-harmed were recruited through posters placed around university campus (see Appendix G), an advert placed on Facebook and snowballing, a form of convenience sampling, through the researcher's network of existing contacts (Patton, 2002 as cited in Braun & Clarke, 2013). The use of social media and snowballing is a common recruitment method used to recruit parents within the field of self-harm research (Ferrey et al., 2016a ; Ferrey et al., 2016b; Hughes et al., 2017; Stewart et al., 2016). Seven interviews was deemed appropriate based on Braun & Clarke (2013) recommendation of 6 to 10 interviews for a small research project using thematic analysis.

2.2.2 MH professionals

MH professionals were recruited by emailing (see Appendix A) practitioners working at a community based young person's mental health charity. Six MH professionals who work directly with young people and who had experience of working with the parents of at least one client who had self-harmed in the last year were interviewed; including two young person counsellors, three wellbeing workers and one family support worker. This included four females, one non-binary trans-masculine and one male. The six professionals were recruited into two focus groups and one interview. Two to four focus groups have been proposed as an appropriate sample by Braun & Clarke for a small research project using thematic analysis (2013).

2.3 Data collection

Data was generated through both one to one interviews and focus groups with parents and MH professionals during March and April 2018.

2.3.1 Parents

Seven semi-structured interviews were conducted in quiet confidential spaces. The design of the interview was aimed towards having a conversation with the intention of understanding the parents' knowledge and experience regarding self-harm (Smith, Larkin & Flowers, 2009). The interview questions were broad and open-ended, providing the participant with an opportunity to explore and provide an in-depth account of their experiences and knowledge, therefore not leading them in their answers, or assuming that they would answer in a specific way (Smith et al., 2009) (see Appendix L). The interview began with a descriptive question:

'*Please tell me a bit about your family and who's in it?'* Starting this way generally allowed the parents to settle in and become comfortable with the interview process (Smith et al., 2009)

The questions went on to explore parents' knowledge and understanding of self-harm using narrative questioning (Smith et al., 2009), '*Can you tell me what your knowledge of self-harm is, and why a young person might self-harm?'.* Evaluative questioning (Smith et al., 2009), was used to ask the participants how they thought parents might feel on discovering their child had self-harmed. For example, '*How do you think parents may respond to finding out about their child self-harming?*'. In a number of interviews the interviewer explored by probing (Smith et al., 2009) with the parent to gain a fuller understanding. The interview was closed by asking the participant if they had any questions that they would like to ask, and thanked them for their time and taking part within the research. The interviews took between 14 to 35 minutes and were all audio-recorded.

2.3.2 MH professionals

Two semi-structured small focus groups were conducted with five MH professionals in each, lasting 50 minutes, as well as a 'one to one' interview lasting 47 minutes. Braun and Clarke (2013) highlight the challenge of using focus groups with professionals whose time is limited, and therefore interview can be often easier to arrange at a time which is more suitable to the individual professional. The use of focus groups was chosen as a way to gain a number of MH professional views at once (Smith et al., 2009, p. 208). Topics such as how to support parents and clients are often discussed amongst staff groups within the children's mental health charity. This therefore offered a natural construct for the discussion (Wilson & MacLean, 2011). The focus group approach allowed the MH professionals to build upon what other colleagues said (Wilson & MacLean, 2011). Broad, open-ended questions were used to explore each MH professional's experiences to ensure there were no assumptions made about how the questions would be answered (Smith et al., 2009) since the researcher was

potentially viewed as an *insider* (Chamberlian et al., 1997) (see Appendix E). The focus groups and interview explored their individual experiences of how parents responded to a young person's self-harm and what support they believed parents found most helpful, asking questions such as '*What would useful support look like for a parent if their child is self-harming?*' The focus group and interview was drawn to an end by asking the MH professionals if they had any questions they would like to ask, and to thank them for their time. Both focus groups and the interview were conducted in a meeting room at a children's mental health charity and all were audio-recorded.

2.4 Ethical issues

Ethical issues were considered fully across both studies, adhering to the British Psychological Society (BPS) code of ethics. Ethical approval was obtained from Chester University Department of Psychology. All data was stored in line with the University guidelines, with data stored securely within password protected files.

Parents and MH professionals who expressed an interest in taking part in the study were sent introductory information which provided them with full details of the research project, explaining what was required of them if they decided to take part (see Appendix C & J). They were also informed about how to opt out and how to withdraw their data and provided with contact details of the researcher and their supervisor in case they had any questions about the research. Interviews and the focus groups were arranged with those individuals who wished to take part in the research. Both parents and MH professionals were asked to provide written consent to their data being used.

As a result of the sensitive nature of self-harm, and although it was not anticipated that any participants would become distressed by the research, a plan was developed following Braun & Clarke's (2013) proposals of managing participants' distress, by acknowledging the distress

and providing the participant with some time, and checking if they are happy to carry on with the process. A debrief sheet was given at the end of the interviews or focus groups detailing further information about the study and signposting participants to organisations and websites which could provide additional information around the topic of self-harm.

In accordance and compliance with the British Psychological Society (2010) Code of Human Research Ethics standard, all research participants were given pseudonyms and locations and names were anonymised.

2.5 Data analysis

All data was analysed using Thematic Analysis, following the six stages approach detailed by Braun & Clarke (2006). A Thematic Analysis approach was chosen because it provided a flexible tool to work with the ontological and epistemological position of the researcher whilst being able to analyse the data fully and in-depth (Braun & Clarke, 2006) (see Appendix O). The phases are detailed below,

Phase 1; the researcher immersing themselves with the data, was carried out by transcribing all interviews and focus groups' verbal recordings by hand. The verbatim transcribed notes were then read by the researcher.

Phase 2; "generating initial codes" (Braun & Clarke, 2006, p. 88), was completed by re-reading through the data and creating a list of words or short statements which summarised the data which was of interest to the researcher. To provide space between the raw data and the generated initial codes the researcher then wrote these out onto paper, noting the line number that the code related to within the transcribed notes (see Appendix O).

Phase 3; the researcher searched for broad themes across the initial code, using highlighter pens to identify codes which fell under the same themes. Reviewing the initial codes, potential

theme names were noted onto A3 paper which summarised the initial codes (see Appendix O).

Phase 4; the themes were reviewed by initially mapping them out and then reviewing the mapping again to produce a second version. With the MH professional data, a flow chart of the themes was produced, whereas for the parents' data a list of themes was generated because they did not follow a pattern as the MH professional data did. Some themes were lost or merged at this stage.

Phase 5; the identified themes were then given appropriate names which fitted well within the context of the research.

Phase 6; while writing the result from the Thematic Analysis, further refining was completed by re-naming a number of the themes to more fully reflect the overall theme. Themes which had been identified but were not specifically related to the research question or not related to the focus of the project were removed.

2.6 Research design

A multiple methods design has been used by the researcher to gain a deeper understanding of the topic of research (Braun & Clarke, 2013), by speaking to parents and MH professionals who were expected to have a different view due to their experiences and the different perspectives they spoke from. As a multiple method design, each of the participant groups has been given equal weighting of importance (Barbour, 1998 as cited in Heath, 2016). The use of both focus groups and an interview due to the logistics of completing the research needed to be taken into consideration, because of different forms of data and understanding that is developed within both methods. Work is required at the point of data analysis to combine the results to ensure that they are compatible (Heath, 2016).

2.7 Reflection on methods

The researcher has experience in the field of young peoples' mental health and has had experience of working with parents and supporting MH professionals dealing with young people who self-harm. The concept of a researcher as insider or outsider of the group of individuals being interviewed is interesting to reflect upon (Gair, 2012). Chamberlian, Stephens, and Lyons (1997) argued, citing sociological researcher Conrad (1990), of the importance within health research of taking an *insider* perspective, where the research has had similar experiences to the individuals being interviewed providing them with *insider* view (Chamberlian et al., 1997). As a result of the researcher's role and their shared experience they took an insider position with the MH professional participants, with a shared understanding of knowledge, language, and terminology. The benefit and limitations of insider or outsider researchers has been widely debated. It has been argued by those who support the insider as researcher that it is not possible to fully understand the experiences of individuals if they have not had a similar experiences and are therefore considered to be an *outsider* (Kerstetter, 2012). This debate regarding the dichotomy of the insider/outsider researcher has moved forward to discuss the *space in-between* (Kerstetter, 2012). The researcher with the parent participants fell within this space, because although they are not the parents of a child aged 16 plus who has or has not self-harmed, through their work they have amassed a great empathy and ability to listen to parents.

The role of power in interviews also needs to be considered (Braun & Clarke, 2013). The parents who were interviewed were aware of the interviewer's MH professional position and it is therefore worth reflecting that this might have led the participants to question their knowledge and to have not been so certain with their answers because they could have deemed the researcher to have a greater understanding of the topic area.

Results

The results from the parents and professional interviews and focus groups have been analysed and presented separately to ensure that both participants' data had an equal voice.

3.1 Parents

Results are presented from the Thematic Analysis (Braun & Clarke, 2006) of the interviews with parents. Five main themes were identified: *Limited Knowledge, View of self-harm, Expected reactions, Parents' need for support and Parents' objectives*

3.1.1 Overall theme: Limited Knowledge

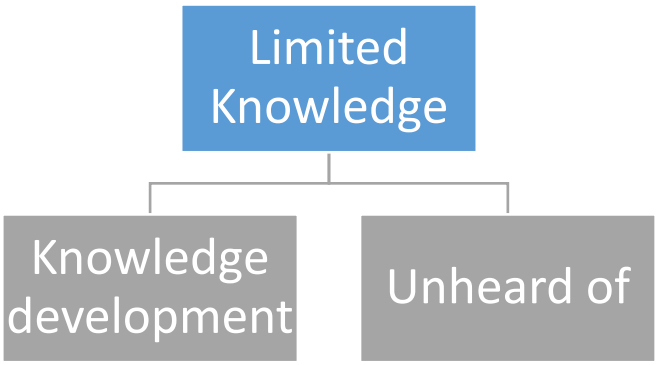


Figure 1: Subthemes in the Limited Knowledge master theme.

All parents felt as if they had an understanding of self-harm, but a number felt that this was limited because of their lack of experience and knowledge. Their knowledge was gained either through the experiences of a friend or family member, or through work or study. Many felt that self-harm was unheard of when they were teenagers themselves.

3.1.1.1 Subtheme: Knowledge development

All parents had some understanding of self-harm, but many felt this was limited. This knowledge had been developed through the experiences of friends, families or through their work or studies.

Chloe: *Gosh. I have a niece that has self-harmed in the past…… It was only when we went on holiday and she actually got into a swimming costume that I noticed.*

Interviewer: *That you could see*

Chloe: *Yeah, that I noticed some of the marks that I had seen at work, previously with some young girls. I have come across it quite a lot at work and kind of reading the signs of the long sleeved tops and the covering themselves up, they are not wanting to be examined, they don't want you to touch them, because they don't want you to see anything. So yeah, probably come across it every other shift I would say, in my job, at least.*

In their discussion of what self-harm was, parents often deferred back to the self-harm behaviours, rather than being able to fully define self-harm. One parent spoke about self-harm behaviour being on a continuum and expressed the importance of the individual's desire of to harm themselves. This highlights that parents may be able to identify self-injurious behaviours without being confident in being able to define them. The insecurity of the knowledge may represent being unsure about what it actually means for children. Chloe's experience highlights the desire of people who self-harm to hide it, until it is starkly revealed. It also could

explain that it is something that parents would need to have some form of understanding of to be able to spot the signs.

3.1.1.2 Subtheme: Unheard of

Many of the parents reflected back to when they were teenagers themselves and spoke about how they felt that self-harm was unheard of when they were younger.

> *Whereas years ago there wasn't. I don't think I remember at all. It was completely unheard of when, or rather unknown maybe (Grace)*

For Grace, self-harm was something which was unheard of when she was younger, but not necessarily something that did not happen. This was reflected in the accounts of other parents who discussed how self-harm was carried out in other forms such as drugs, overdoses and eating disorders. They further reflected on whether this was as a result of people not knowing much about self-harm at the time, with more recent awareness around self-harm increasing.

Parents felt that self-harm perhaps happened in different ways when they were younger.

Rose: But like self-harm would have been in the 80s would have been drugs, alcohol, you know that solvent, you don't really hear about solvent any more. That seems to have, I don't know if it is still there. I don't hear so much of that sort of abuse before, whereas that was quite big when I was a teenager. I think it is most probably still there, but I don't hear about it talked about the same.

Interviewer: *It is interesting that, isn't it, how there was sort of self-harm but we didn't probably call it self-harm?*

Rose: *Yes, it didn't have a label. Because a lot more things have got more labels now, haven't they?*

Rose spoke about not seeing self-harm such as cutting taking place back in the 80's. This might be a reflection of people not being aware of cutting as a self-harming behaviour at that time because of the lack of awareness surrounding it and therefore the lack of conversation about it. Rose went onto reflect that people did self-harm, but they did it in different ways such as overdoses, drugs, alcohol and eating disorders, which didn't at the time have the label of self-harm. It may also suggest that there have been changes in the behaviours people choose to self-harm, as Rose reflected that she no longer hears about solvent abuse. There was a feeling that society had changed during this period with self-harm developing a label which provided people with more knowledge about what self-injurious behaviours meant.

Parents spoke about there being an increased understanding of self-harm today

> *I think it is getting better because I think maybe five, eight years ago it was a lot more covered up than it is now. Now whether it is because it has increased I am not sure. But you do, they do seem to be addressing lots mental health, whereas they weren't before. So it is coming out more in the open; it isn't as much of a stigma as it was (Rose)*

It was felt that the general public's awareness of mental health was increasing and was being discussed more by people, leading to an increased awareness of self-harm. This increased awareness was associated with a positive change in reducing the stigma surrounding mental health issues and self-harm. A number of the parents questioned a possible paradoxical

situation of self-harm with the increase in awareness, perhaps leading to increased levels of self-harm. Although parents felt that there was less stigma regarding self-harm today, there was still a recognition that people do not feel comfortable talking about it.

3.1.2 Overall theme: View of Self-Harm

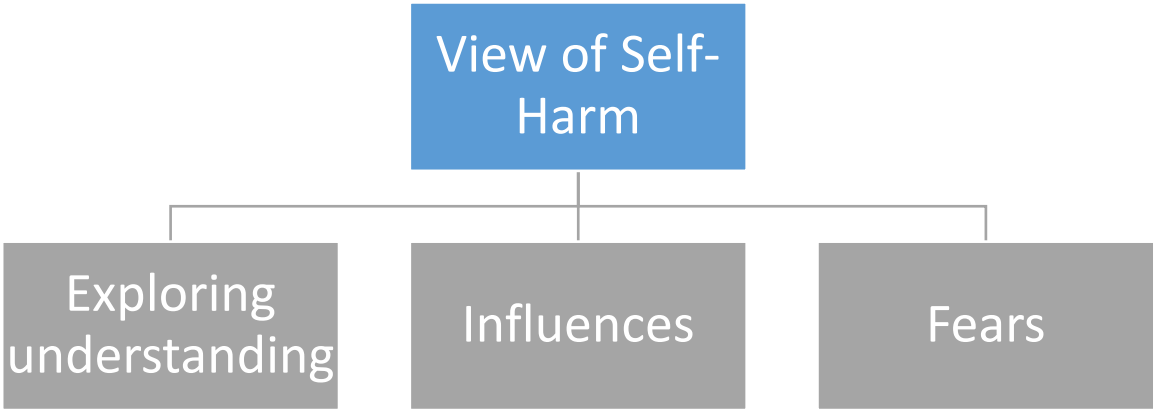


Figure 2: Subthemes in the Views of Self-Harm master theme.

Parents' views of self-harm were linked to their understanding of why a young person might self-harm. They discussed what factors might influence a young person to self-harm and their fears surrounding self-harm perhaps developing into a suicide attempt or becoming habitual.

3.1.2.1 Subtheme: Exploring understanding

Parents felt that young people self-harmed due to a range of reasons, including a response to overwhelming emotions, a cry for help, and attention seeking. How a number of parents felt

about self-harm was linked to the reasons why they believed the young person chose to self-harm.

> *My friend, she, she, she missed that moment when, when her daughter, umm, it was too much for her, it was the load those loads more problems on her head and I think, this is like a release of emotions, something like release, for teenagers, and for, and I think for adults this is also the same, emotionally too big a problem to cope with. (Evie)*

There was an agreement amongst parents that young people often self-harmed when emotions were too overwhelming for them to deal with. Evie believed that self-harm was something which could have been prevented by others being more observant, and that an intervention needed to take place before a child reached a "critical point". There was reflection that parents may not have observed their child's distress at the time because they were consumed and struggling within their own emotional response to a situation.

A number of other reasons were cited by the parents as the reasons why young people might self-harm. These included self-harm being carried out because of a "trend" amongst young people, a form of communication such as a cry for help or by the young person "for attention seeking" purposes.

> *I was cross and shocked and annoyed because like I say about the attention seeking thing, I thought well, if you are all doing for attention what about the girls who are doing because of actual issues. No one is going to see to them because you're all just being attention seekers and and it made me cross and why would you do that to your own body? (Dot)*

Parents talked about reasons for children to self-harm, such as distress. However, for one parent, young people that they deemed to be self-harming for attention seeking purposes were

derided and considered to be taking support from other young people who needed that support. Other parents took a different viewpoint regarding this use of self-harm as a form of attention seeking. One parent explained that if a child was self-harming to attention seek, then it was because they were lacking love, affection, and attention in their lives. Another parent felt that young people would not inflict harm upon themselves to seek attention because there were other ways of gaining attention without causing pain to themselves.

3.1.2.2 Subtheme: Influences

Parents discussed a range of factors which they thought influenced young people's self-harming.

> *There are families that do absolutely everything for the children, provide for them, and do everything and they still self-harm. I think there is a lot of peer pressure and a lot and put it out there. I think the internet has a lot to do with it, massive. Massive impact on children now, and how they think they should look and how they think they should behave, what they think is socially acceptable. And what if they haven't got as much as what someone else has got that they can see on the internet? They kind of think that they are a failure. (Chloe)*

Parents spoke about the wider pressures that young people face through what they view on the internet and social media. They considered it to have a negative impact on young people's lives, since they have to live up to an idea of a perfect life portrayed by people on social media. It was felt that young people did not understand that that type of life was not real and therefore they were seeking something which was not possible to achieve, leading to feelings of failure.

There was also the concern about the increased awareness of self-harm and also the contagion effect.

Or whether because it's they see other people doing it, they think it is OK to do it, would have they done it without that knowledge of other people doing it. (Rose)

Only two of the parents spoke about the possibility of a young person self-harming because they had seen a friend or someone else self-harm who might not have considered it before. This was understood by parents to be due to the increased knowledge of self-harm amongst young people.

3.1.2.3 Subtheme: Fears

Parents expressed a number of fears they would have if they found out their child had self-harmed and concerns about how self-harm might be used by young people

I would hope it's not something like a badge of honour. That, that's would be quite disturbing to think about it, wouldn't it? (Grace)

Parents expressed a range of fears regarding self-harm, including an escalation to suicide, that self-harm would become a habitual coping strategy, and would be used as a *"badge of honour"*. Drawing these issues together, it was clear that parents were concerned primarily about the escalation and habituation of self-harm behaviours.

3.1.3 Overall theme: Expected Reactions

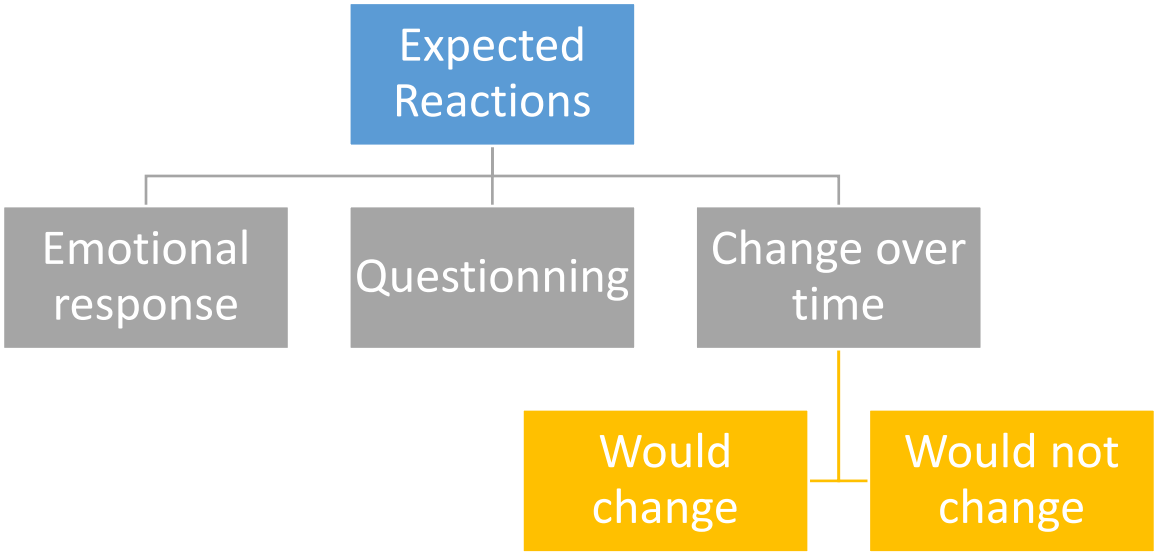


Figure 3: Subthemes in the Expected Reactions master theme.

The participants spoke about a range of responses which they would expect from parents on finding out about their child's self-harm. They understood that parents would have an emotional response to a young person's self-harm, including guilt. They felt that the discovery of self-harm would lead to parents questioning themselves. There was a difference in opinion about whether a parent's response would change over time. Some thought parents would always be in a state of worry, whereas others felt that the worry would lessen with more information.

3.1.3.1 Subtheme: Emotional response

Participants recognised the distress that parents would experience on finding out their child had self-harmed.

> *Obviously worry is the main one, because if your child is self-harming you know they are going down a road, a dark road and you know it is going to take a lot to make them see the light, as it were, and you are going to be very worried, on a day to day basis after*

finding out that knowledge. You will be, constantly, you won't, I don't think it would leave your mind. I think you would constantly, always thinking about it and always thinking about the situations that your child could be in that day. So, I think you are always going to be in a state of worry after that. Yeah. (Alex)

Parents recognised that they would have an emotional response to a child's self-harm, including distress and ongoing worry for their child, which would take a while to abate. They would become inwardly reflective, speaking about self-blame and how they would feel they had let their child down. The responses of shock, fear, worry, and self-blame were generally constant across parents. One parent, however, spoke about how the shock of finding out might lead them to be cross with their child. This was associated with the perceived lack of control parents would have in that situation, chiefly as a result of their lack of understanding of what self-harm is and how they could provide appropriate support.

3.1.3.2 Subtheme: Questioning

Parents felt that the discovery of a child's self-harm would lead them to question themselves.

You would be thinking I have let my child down, you know, this is my responsibility, what I have done to create a situation, because I guess it is that thing about if I was suddenly to find out that my son was self-harming, for me it would be about how I've not noticed what it is that is going on in his life and how has that gone this far, that he has ended up in that situation? So I guess I would reflect on myself and as a parent I would be thinking woo, what is that, you know, what I have done to, to create this scenario, and even though that might sound a little but irrational. (Frank)

All parents felt that the discovery of a child's self-harm would lead them to question their ability to parent, how they may have contributed to the self-harm, how they failed to see warning

signs and what precipitated it. It was felt that the discovery of self-harm would be a shock to them as parents and it would undermine their confidence as a parent, feeling they had failed their child, and leading them to blame themselves in some way for the self-harm or for allowing the child to get to a point of distress.

3.1.3.3 Subtheme: Change over time

The parents were split into two dichotomies in how they felt a parent's response to a child's self-harm would change over time.

3.1.3.3.1 Would change

A number of the parents felt that the response of a parent to their child's self-harm would change over time, as they gain information and support.

> *You would hope that the avenue you go down for, for the support would be doing some good. And you would feel better about it that they were getting the help that they needed. I would imagine that you would feel a little bit impatient if you went on a long time, thinking are they getting the help they need? (Grace)*

Grace felt that with the right support parents would feel better over time. However, this would depend on there being progress in the child's recovery. There was an underlying assumption that the child would get better and as result of support they would stop self-harming.

3.1.3.3.2 Would not change

A number of the parents, however did not agreed that parents' response would change over time. They felt that there once a parents was aware of the self-harm they would never stop being concerned.

> *And I think you will always be aware of the that situation for duration of your child's life time. It will always be something that is a possibility, that could re-emerge. So, yeah, you would be thinking about it personally I think, about it for the rest of their life basically, because if it has happened once, it can happen again. Even if that consolation and where recovered you would still think about it, you would still, if you see them upset you would think to yourself, is there a chance it could happen again? I think you would always think about it. (Alex)*

Alex constructed the worry parents would feel for their children as never-ending. After finding out about the self-harm, Alex felt that parents would always worry about whether their child would self-harm again.

3.1.4 Overall theme: Parents Need for Support

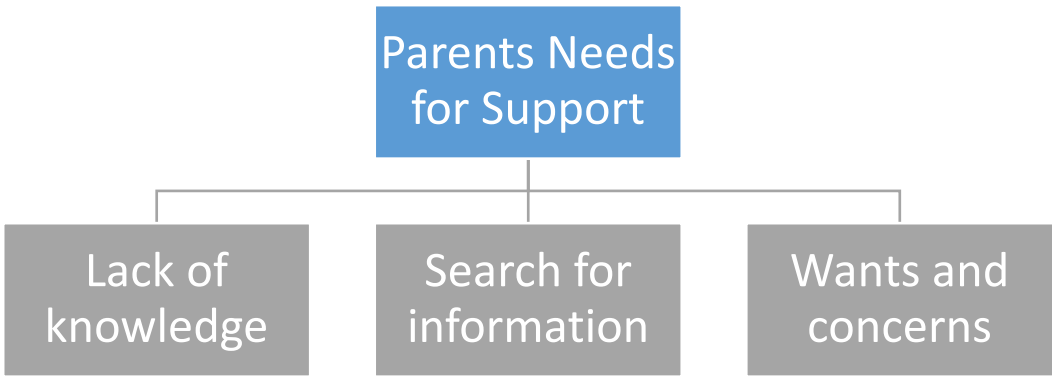


Figure 4: Subthemes in the Parents Needs for Support master theme.

Participants acknowledged the need for support for parents when a child had self-harmed. They lacked the knowledge of where parents could gain support and this would lead them to carry out a broad search for information via the internet. They spoke about what parents would want from this support and their concerns about progress.

3.1.4.1 Subtheme: Lack of knowledge

There was a lack of knowledge of specific services to support parents of children who had self-harmed.

Interviewer: *Do you know of any support services open to parents, if there were child who had self-harmed?*

Alex: *To be honest, I don't. If my daughter came home tomorrow with these problems, I would have to look on Google, and find out who, what kind of treatment would be needed and who can provide it in the local area.*

Participants generally felt they had a lack of awareness of available support services for parents of children who had self-harmed. Many parents spoke initially about carrying out a broad search for information on the internet because of their lack of awareness about where to get support from. The internet would be a starting point for them where they would hope to find further information about support services.

3.1.4.2 Subtheme: Search for information

The lack of knowledge of support services meant that parents would seek out information.

> *I don't, I don't know if there are really, I would imagine, that, you would Google it, or you would ask, you would see your GP, something like that. Pretty quickly. I would be round there straight away. (Grace)*

There was a consensus from parents that they would seek out support, predominantly online. They would want quick access and the information to be helpful immediately. The need to "Google it" highlighted that parents start from a position of having little knowledge of support services, and turn to the internet, rather than professionals, as a primary source of information. They would be looking to amass a wide range of information regarding self-harm because at this stage they would not know exactly what information they would need. After searching online, the parents named a number of sources including their GP, school, and Childline as possible avenues for support. However, they were unclear about what specific support a parent would get and felt that the support would be targeted more towards the young person than to their parents.

3.1.4.3 Subtheme: Wants and concerns

Parents were clear that they would need information, require professional guidance and they were concerned about having to wait for support for their child.

> *I think so also professional, therapist, because, because they, from my perspective, if something happened, if I can imagined something happened I would, I would seek some help, professional help, and just even to guide me what to do. Definitely, definitely, I think it is a good idea. (Evie)*

All parents were in agreement that they wanted support. They wanted the support to be from an organisation or a professional who they considered to be experts in self-harm. That although initially they would "Google" for information, in the longer term parents would want support from a trained professional. Their need for an expert is likely to be because they do not feeling as if they have the right level of knowledge or experience to deal with the situation. They want information quickly to give them strategies for helping their child. One parent felt that they would want to know how they can stop their child's self-harm and how they can gain a level of control over it with the objective of supporting their child, but they also felt knowing what to do would reduce their own fears. There was concern from parents that if their child had to wait for support such as counselling their child would get worse.

3.1.5 Overall theme: Parents' Objectives

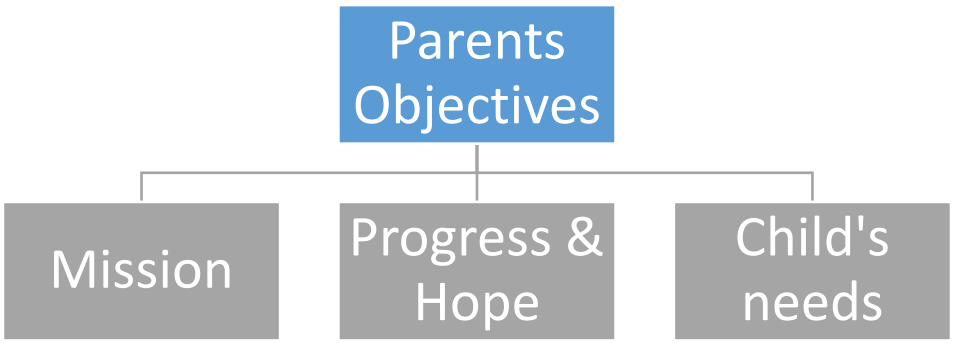


Figure 5: Subthemes in the Parents Objective master theme.

Participants spoke about additional objectives they felt parents would have. This predominantly focused on them supporting their child to recover. They also wanted support

services to provide hope and to be able to show progress in their work, exploring what they felt a young person's need would be if they had self-harmed.

3.1.5.1 Subtheme: Mission

Parents felt that the overriding objective for a parent would be for their child to recover.

> *Expectations, at the end of the day, any parent is expecting them to help your child to recover fully. (Alex)*

The parents' mission for the support they and their child would receive was for their child to *fully* recover from self-harm. They spoke about wanting to get to the root of the problem. Their ultimate goal was for the child to stop self-harming as it was distressful to them as a parent. They believed that the sign of a child's recovery would be that they had stopped. There is the expectation that professionals would make their child better and there was an overriding sense of urgency for this to be achieved.

3.1.5.2 Progress and hope

Parents wanted progress and hope from support provided to their child.

> *I suppose it is that thing, you want to, you know to a degree unfortunately you want to fast forward to the end so you to know that the support that you are going to receive is going to have the benefits that you want it to have, so it is just knowing that whatever process you are about to enter into will have dividends for your child, and you, you want to know that, and you want have a bit of faith in the process (Frank)*

Frank spoke in the most detail about wanting certainty in the process. He used the analogy of taking a child to a hospital with a broken arm. A parent would not be happy if the doctor explained that they may or may not be able to fix it. He felt that there were no certainties

provided around the treatment of mental health conditions such as self-harm and as a parent he would want to know that there would be progress the treatment offered. Other parents also spoke about wanting some certainty that they had chosen the right support and that the support would help their child to recover. Overall, they want hope, hope that their child will get better and hope that the support process will work for their child.

3.1.5.3 Child needs

Parents spoke about the child's need for support from both their parents and professionals when they self-harmed.

> *I guess it is that thing about, it's about the young person and in terms of umm, moving that young person on, it really does start with them, and what, what are their needs and what will work for them. And you know, I know for example, you do walking, I suppose its about just it being non-perceptive and working with the young person to identify what they feel makes them, I suppose you know, in a really crass way what makes them feel better than what they are feeling at that point in time, so, so yeah. (Frank)*

All parents felt that children who had self-harmed needed to be listened to. They felt that this was a skill that parents needed to develop, the young person would also need a professional to speak to and this service would need to be child-led and built up from the needs of the individual child. It was important to one parent that this service was a safe and welcoming place for the young person as she felt that the professional may need to build a close relationship with the child if she had, as a parent, lost the connection at that point.

3.2 Mental Health professionals results

Results are presented from the Thematic Analysis (Braun & Clarke, 2006) of the MH professional's focus groups and interview, which included counsellor, wellbeing workers and a family wellbeing worker. Three main themes were identified: *Initial response and actions by parents; What parents want when a child self-harms; and The role of the MH professional*

3.2.1 Overall theme: Initial Response and Actions by Parents

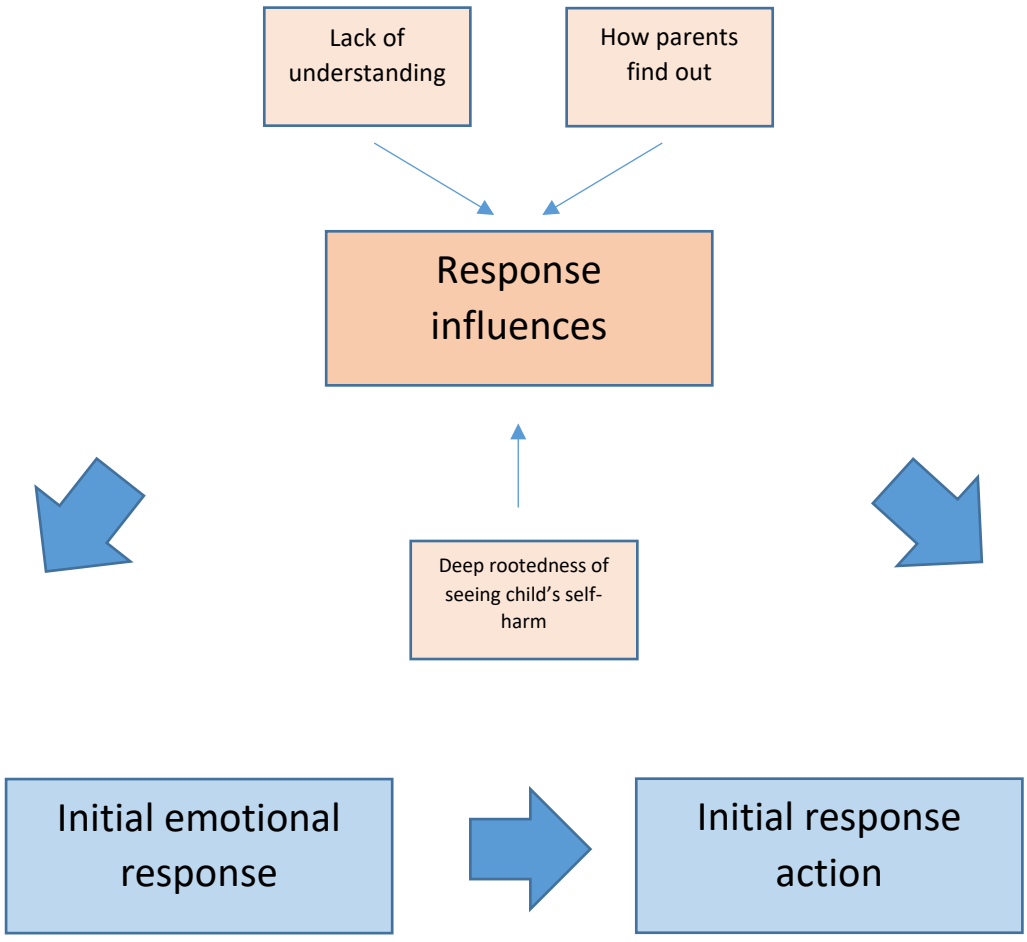


Figure 6: Subthemes in the Initial Response and Actions by Parents master theme.

In their experiences, the Mental Health (MH) professionals felt that parents have an initial emotional, response, including shock, panic and fear, on discovering about their child's self-harm. The level of their emotional response in terms of their own distress of the child's self-harm, impacts on how they respond to their child. There are a range of external and internal influences which effect parents' initial emotional and response actions to their child, which includes; their lack of understanding about self-harm at time of the disclosure; how they find out about their child's self-harm and the deep impact seeing their child self-harm has on them as parents.

3.2.1.1 Subtheme: Initial emotional response

All MH professionals agreed that parents initially have a wide range of often overwhelming emotional responses to the discovery of their child's self-harm.

Bella: *I would say the best analogy would be a rabbit caught in head lamps.*

Alice: *Panic and fear*

Bella: *Distraught*

Alice: *Yeah panic and fear*

Bella: *and guilt.*

Charlie: *And unsure, really unsure of what to do for the best.*

Interviewer: *Would you say that is kind of constant across the parents you work with?*

Alice: *Yeah and I think there is a general assumption from parents that self-harm leads to suicide. You know and that is where a lot of the panic and fear comes from.*

Bella: *I think surprise as well. I think there is a lot don't have a clue and they think that everything is OK.*

Charlie: *I think with that surprise as well, I think it is also the guilt that they haven't noticed something.*

Alice: *Yeah they feel responsible*

Bella: *Yeah they think they are responsible.*

Charlie: *How could I have stopped this? If I had known could I have done something?*

Alice: *Yeah, have I contributed to this. Could I have done it differently?*

All MH professionals stated that parents initially had an emotional response to the discovery of their child's self-harm. Typically this emotional response was overwhelming and MH professionals explained that most parents were distraught. Some parents were shocked because they did not anticipate the disclosure and had not noticed anything in their child's behaviour which concerned them. The MH professionals identified that often parents experienced panic and fear that the self-harm will either lead to suicide or they misunderstood it for a suicide attempt. The MH professionals discussed parents who would blame themselves and question their abilities as parents, with parents feeling responsible for the self-harm. Quite often, the MH professionals felt that parents felt ill-prepared to support their child and felt unable to seek support from others out of fear of being judged. Broadly speaking, the discovery of self-harm was a traumatic event for parents, which altered how they view themselves and their child.

3.2.1.2 Subtheme: Response influences

The MH professionals believed a number of factors influenced parents' initial emotional response and actions to their child's self-harm were identified.

3.2.1.2.1 Lack of understanding

All MH professionals spoke about the lack of understanding that parents had in general about self-harm, what they can do to help their child and where to find support.

Harper: *I think it's kind of, if they don't understand self-harm, that not understanding really impacts on their ability to then support the young person. And so they, they, come out in a very emotional based responses as well, as you would do. Rather than kind of, supportive response which is where you get the real mixture from, kind of. Or just trying to find a way to answer it. So is it, they run through I guess all of the stereotypes, it is attention seeking behaviour. Does it mean they're going to kill themselves? And they, they kind of, one bit is to go to the extreme of kind of catastrophisation and kind it's really bad and they are going to kill themselves.*

Leon: *There's always a kind of, I don't understand it, I don't understand it, as well. I come across quite often. It, struggling or deliberately not empathizing with the behaviour, if you know what I mean. Like, I can't understand why you do that.*

The MH professionals felt that parents in general had a lack of understanding about self-harm, including not understanding what self-harm is, motivations for self-harm and confusing it with a suicide attempt. As a result of the parents' lack of understanding of self-harm, they were confused as to what to do and what to say to their child and felt ill-equipped to deal with their child's self-harm. Due to the lack understanding of what support was available

meant that parents responded to the self-harm emotionally. MH professionals felt that parents' misunderstanding of self-harm as suicide attempts lead them to have an overly emotional response, hence Harper's reference to *catastrophisation.*

3.2.1.2.2 How parents find out

From the MH professionals' experience, the way parents found out about their child's self-harm had an impact on the way they responded.

Interviewer:	*So what is your experience of how parents find out children self-harmed. So how did they find out?*
Leon:	*Mine have mostly been because they have told them.*
Ellie:	*Yeah told them or, like in summer they are going around with long sleeves tops on.*
Leon:	*Or read their diary, I had that one.*
Interviewer:	*Can you say that again?*
Leon:	*So Mum reads their diary.*
Interviewer:	*Okay*
Ellie:	*So little things like that, or not they are not, if they suggest go swimming or something like that and they don't go*
Interviewer:	*Right*
Ellie:	*Because that's like the higher up ones that are doing it then or even just blood on a shirt, just ask how've you got that?*

Harper: *For some of the parents I have worked with, it has not been until somebody told them, another MH professional, so like, the young person spoke to schools and school have told parents.*

Interviewer: *Do you think there's a difference in when they're told through school or when the child tells them themselves?*

Harper: *I think there is a different response. Because I think if they get told by another MH professional they get all, they get information along with it, so they get shocked that they didn't know themselves and they might still go through some of those emotions. But in terms of then their response to the young person it can be slightly more measured because then they've got, they have had that conversation and they have some information to go with.*

MH professionals identified a range of ways in which parents found out about their child's self-harm. This ranged from the stark revelation when the self-harm had gone wrong and the young person had gone to the parent when in distress for help, to being informed by a third party such as a teacher. Some parents had noticed a behaviour change in their child and had begun trying to identify why their child was acting differently, with some reading their child's diary. For other parents they noticed the self-harm marks on their child or found the implements used. MH professionals felt that the way parents found out about the self-harm influenced their response. If the self-harm had gone wrong, this was deeply shocking for parents and not only did they have to respond to the child's self-harm injuries but also to the child's distress. Whereas when parents were informed by a third party, it provided the opportunity and space for parents to gain some knowledge and understanding before they needed to respond to the child.

One MH professional discussed how parents communicated about their relationship with their child following the discovery of self-harm.

> *I feel like where they have kind of told the parents and my experience is kind of limited, but it's been, they have kind of gone out of their way to tell me what a great relationship they have got with this child, because the child has been able to tell them. And maybe and maybe they think I'm judging them because they have allowed their child to self-harm, or something, or their child is not happy. They are like we've got this great, he tells me everything. I'm OK. Maybe there is a bit of that. (Leon)*

Leon discussed his feeling that for some parents they had wished to make it clear to the MH professional the strength of their relationship with their child. Leon felt that this was reflecting that parents had been fearful that the MH professional would judge or blame them for their child self-harm. Expresses the guilt and shame felt by parents that the MH professional could believe they had allowed their child to self-harm.

3.2.1.2.3 Deep rootedness of seeing child's self-harm

All MH professionals commented on the deep rootedness of the impact of a parent seeing their child's self-harm and the level of distress this caused to the parents.

> *And as a parent myself, you kind of can't think of many things worse, than something hurting your own child. So it's really deep rooted stuff for parents and for anybody you know. Well hopefully most people don't want to see a young person getting hurt, when it is your own it becomes a whole different a different ballgame. You know, counsellors will tell you, you know, I am really good at dealing with other people's children and when they hurt themselves, but if it was my own child I know I would be,*

kind of worried and I would want this. So it's a very, very personal battle for them as well. I think it's really locked into to what we are as humans to want to protect your child and you would kind of do anything. (Charlie)

For the professions, a young person's self-harm tapped into the primal human behaviour of a parent to protect their child. The MH professionals explained that self-harm is distressing to parents because of the natural response of parents to protect their children from pain and their desire to take pain away for their child. This understanding, the MH professionals argued, often made it difficult for parents to understand their child's self-harm. One of the MH professionals likened the discovery of a child's self-harm to one of the largest stresses that people can experience in life. They explained that due to the depth of the distress and trauma experienced it was likely that parents own wellbeing would be affected.

One MH professional spoke about how the self-harm impacted parents if they had self-harmed themselves in the past.

I think there is an element, there are going to be those parents who have been self-harmers themselves. So when they hear that their child has self-harmed, I think, that there is that 'oh gosh, has that come from me, do they know', there is definitely a blame sense, but it can also trigger that parent back to that time of self-injury. And then they can find it really difficult to be in their child's journey, because actually they have gone back to their own journey. (Alice)

Alice spoke about the impact on parents who had self-harmed themselves and their child's self-harm could act as a trigger, taking the parent back to their own previous struggles. Alice explained how parents had found it challenging to be present for their child when they were self-harming because it had returned them to their own difficult feelings linked to self-harm.

3.2.1.3 Subtheme: Initial response action

MH professionals reflected on a variety of responses which parents had to their child's self-harm, explaining the possible impact of the response on the child.

Alice: *I think a lot of the the times they want to question them to every inch of their life, they want, they think that they can help them. Which they can. But they, they want to do it at their pace rather than the child's pace. So they don't necessarily listen to the child's voice. And that is where we teach them to actually, they have got to take a step back and actually just let child know what they will always be loved unconditionally, that they are there for them when they are ready to talk. And I think because they panic, I think it almost comes across as that questioning, why are you doing that? Why are you doing that? That has got to stop. It can feel quite condemning for the young person, I think.*

Bella: *I don't think that it the intention of the parent.*

Alice: *It is not the intention of the parent, I think. They are stressed, their panic is what is present, so that is what they are going with. So you certainly, our work, you know, as I said before, is about trying to manage that more sympathetically more empathically for that client.*

Bella: *I think they. I think because of the lack of awareness, the numbers involved with self-harming, I think, there isn't that education there. That skill set to deal with it and, they just want to fix it. And they don't realise they have to back off, they found out and it has to be on that*

child's terms now and it has to be within their control they have just got to be supportive. But I think, just before you end that, I think it's, they soon learn. I think it is a knee jerk reaction and I think majority of them want to seek help, don't they?

MH professionals spoke about how the fear of the child's self-harm often led to a knee jerk reaction by the parent, by questioning the child or wanting the self-harm to stop immediately. The MH professionals reported that the parents wanting to take control of the situation and often remove the objects being used by the child to self-harm. This reaction, according to the MH professionals, sometimes scared the child and put them off seeking support from parents in the future. The MH professionals also reported that parents' responses were usually unhelpful to the child self-harming and ranged from hyper-vigilance of their child, to the young person being punished for their self-harm, or told their behaviour was stupid. Some parents ignored the self-harm, which was understood by the MH professional to be because the parents did not know how to deal with the situation. One MH professional spoke about parents sometimes over-compensating with kindness and not identifying and addressing contributory issues. Despite the parents often lacking skills, the MH professionals felt that the initial response of most parents was to want support for their child.

3.2.2 Overall theme: What parents want when a child self-harms

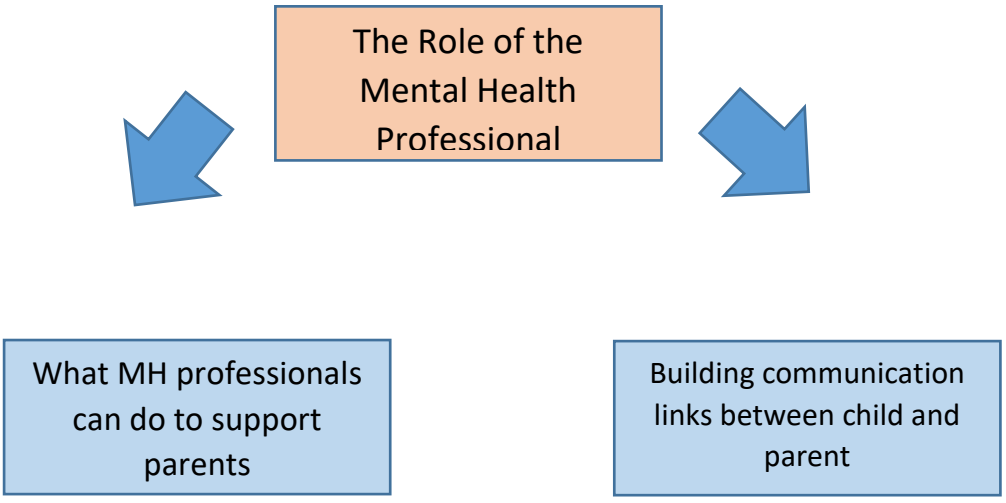
Whilst some parents, the MH professionals reported, disengaged from the situation, the majority wanted to help their child and wanted to know what they could do to stop the self-harm.

They are just trying to find the cause. "Tell me the cause and I can take the cause away and we can fix it". "Tell me how to fix it, what do I need to do, write it down for me, I need to do it, I'll do it". (Bella)

MH professionals thought the overall objective of parents was to understand the cause of the self-harm so they could fix the situation. Parents wanted advice from MH professionals so they knew what to do and how they could help their child, with the eventual goal of ceasing self-harm. The parents were looking for reassurance that they were doing the right things because they did not trust their own judgement. One MH professional spoke about the importance of confidentiality to parents, who had joined a parent support group because the parents felt that by speaking to a MH professional they had gone against the wishes of their child to not tell anyone else about the self-harm. The parents had wanted complete re-assurance from not just from the staff member but also the other parents that what was said would be confidential.

3.2.3 Overall theme: The Role of the Mental Health Professional

The MH professionals felt that they had an important role in supporting the parents of child who had self-harm by providing education about self-harm, giving reassurance and providing the opportunity for peer support. The MH professionals constructed themselves as playing a key role in bridging the communication gap between parents and young people.



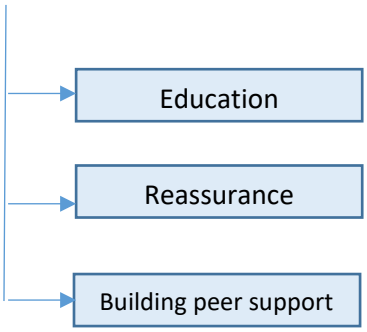


Figure 7: Subthemes in the Role of the Mental Health Professional master theme.

3.2.3.1 Subtheme: What MH professionals can do to support parents?

The role MH professionals felt that they had in assisting parents fell within three themes; Education, Reassurance and Building peer support.

3.2.3.1.1 Education

The MH professionals saw one of their main roles in helping parents was to provide education to parents including 'what self-harm is and is not' and to provide strategies which they can use to support their child.

> *Yeah I think so, yeah. I think, when you work with parents and you work with the client and you do then begin to work with in terms of, in developing their own knowledge, their own understanding of what self-harm and self-injury is, that it is more of a coping mechanism and it doesn't necessary mean that it is suicide, that it will lead to suicidal thoughts/ intention. It can happen, but we really do educate the fact that it is not that immediately, that it is a coping mechanism and I think that once they have that understanding and once we kind of, equip them and the client with a range of coping strategies which they can then go away together and work on*

together to support one another. I then think that journey does feel more, less anxious for the parent. (Alice)

All MH professionals felt that one of their main roles was to provide education to parents regarding self-harm to develop their knowledge and understanding. They explained that parents want to know how to stop the self-harm and they saw this as the initial step towards. One of the main messages they wanted parents to understand was that self-harm is a coping strategy rather than a suicide attempt. They felt that if they had normalise self-harm more for parents, parents might react less from fear and be in a stronger position to provide support to their children. They had wanted parents to understand that it might take time and that they needed to go at their child's pace. They spoke about equipping parents with strategies that they could use to support their child, such as listening to their child, providing unconditional love, providing a balanced response which was understanding, supportive and not punishing the child. MH professionals spoke about their experience of providing education and helping the parents see the self-harm as a form of communication and a way to release emotions. They worked with parents to understand the need that the self-harm was meeting for the child and suggesting appropriate strategies which parent could use to help their child. They felt that increasing the parents' knowledge regarding what self-harm is and what they can do, assisted parents to feel less anxious and understand the process as a journey which they are taking together with their child. The desire to educate parents came from the MH professional experience of treating young people who self-harmed rather than from the request from parents.

3.2.3.1.2 Reassurance

MH professionals felt that parents often doubted their ability to support their child at that time and were looking for reassurance to strengthen their confidence to deal with the situation.

Leon: *It is their confidence as well and their ability to support them, I think they do want to but then it takes a little while once they've got that. For them to get the right information to know that they're doing the right thing, because they want to support but they don't know what, how to do that. But is like a confidence thing. A lot of the time, I find when you kind of say to, your relationship is a big source of resilience.*

Interviewer: *Yes.*

Leon: *That kind of reassures that we already do a lot if you know what I mean.*

Ellie *I think it is the part that kids don't come with manuals, so you can't go to page 59. Self-harm. It's sort of like as a parent you have to do, things often from your gut instinct half the time. And then when you don't it's like you're a bad mother because, you don't know how to do it. So sometimes that can stop parents from reaching out, but then that causes them to have anxiety which then has an impact on the child. But, I am going say, most of the ones that I've talked to afterwards and they've gone away and they have read the information that I've given to them and they come back they said how nice it was actually to speak to somebody that was not judging them because they didn't feel like they could talk to quite a lot people because they might be actually judging them on their parenting skills.*

The MH professionals saw providing parents with the right information and a non-judgemental space as providing them with scaffolding, reassuring them that they can help their child and that their relationship can provide a source of resilience. The MH

professionals spoke about providing a listening ear to parents, so they could act as buffer for the parents' anxiety, so this is not passed onto the child.

3.2.3.1.3 Building peer support

There was agreement across the MH professionals regarding the benefits of a parents' support group, allowing parents to know that other parents are going through similar experiences.

> *Parents' peer groups. I think I've been to where, obviously where we are I think parenting parents support groups are fantastic. I think, I think not long ago we had parent support group with six parents in there whose children were self-harming or felt suicidal. So the worker who ran that, asked me to go in there and just do a little talk around self-harm. Actually what it is, what is it about, what to do if things went beyond that and how to recognize that that was the case. If that was if that was possible. And you know, knowing that they're not on their own, there are other young people doing this and there are parents who are equally as worried and are finding ways to cope and are finding ways to help the young person, that sharing of knowledge is fantastic because self-harm is certainly more known about. (Charlie)*

All MH professionals felt that that they had witnessed great benefits to the parents who attended the parent support group. They felt that the group provided parents with a comfort to know that they are not alone. The parents were able to provide scaffolding for each other by sharing their own experiences and the strategies they had tried. The MH professionals felt that for a parent to gain guidance and validation from other parents was more valuable to parents than the work they could do on their own. One MH professional spoke about the "sigh of relief round the room" following parents explaining to each other why they were attending and the realisation that they were not alone with their situation. By sharing their

experiences, parents were aware that they were not the only parent who's child is self-harming and this sharing of experiences had meant that they felt less isolated.

3.2.3.2 Building communication links between child and parent

MH professionals regarded part of their role to be building the communication links between children and parents and saw the self-harm as an opportunity for parents to improve their relationship with their child.

Leon: *I was trying, like in drop in, when the parents are there, I always trying to frame it as, this is actually kind of a good thing that this happened because it's come to light to light. This is the beginning of a conversation and the change in your family. And you know if you, you know it doesn't have to be like this if you know what I mean. So, I always think kind of, without without saying but it's so good that your child is self-harming. It is kind of like this is actually a real opportunity for you guys if, there is nothing to be afraid of kind of thing. So, I mean obviously that's in an ideal world and not everyone feels like that.*

Ellie: *I mean it quite true though, if everything is running well in a family you just carry on doing what you've been doing. But once you get like a bit of a hiccup you start analysing how we can change things and make it perhaps into a more functional family. Spending time, because we'll get stuck in it, in a part where things tend to be more important and we don't mean to show that.*

MH professionals deemed themselves to be able to bridge the gap between parents and

young people, to facilitate the strengthening of communication and connection between them and assisting the young person in communicating their needs to their parents. The MH professional felt that both parents and their child found it difficult to speak to each other about the self-harm. Parents were concerned that they would say the wrong thing and young people were concerned about the detrimental impact finding out about the self-harm could have on their parents. MH professionals considered they also had an educational role with young people regarding the importance of their connection with their parents, guiding young people on ways to communicate with parents.

One MH professional spoke about the importance of including the parents in the therapeutic process, because they could carry on the work outside the sessions and be the person that the young person could turn to when they felt that they wanted to self-harm. Another MH professional echoed the opinion of Leon that the discovery of their child's self-harm could be view as an opportunity to start the conversation which might not normally arise in everyday life, to make changes within their family and to improve their relationship. Far from judging parents negatively, the MH professionals believed that this was a chance for the family to gain an understanding of what was happening for them and with the support of the MH professional, to work on improving the bond between the child and parent.

Discussion

The experiences of parents, within the self-harm literature has been focused on those whose children have self-harmed and have been involved in some form of treatment within a clinical setting (Byrne et al., 2008; Morgan et al., 2013; Oldershaw et al., 2008; Raphael, Clarke, & Kumar, 2006). Little attention has been paid to exploring the understanding and experiences of parents whose children have not self-harmed. Furthermore, despite professionals holding a unique position to the parents and young people who self-harm, their experiences are often overlooked. Consequently, this project was intended to redress this imbalance and explore experiences and understandings of parents of young people and Mental Health (MH) professionals in order to identify key issues facing the parents of those who may self-harm. This was achieved through addressing three research questions, from both the parents and MH professionals' perspective;

What are the perceived issues for parents if their child self-harmed?

How would/do parents respond to self-harm of a child?

What support needs do parents need or want?

In order to meet the aim and research questions, one study was completed using a multiple methods approach, capturing two voices. The first part of the research explored the knowledge and understanding of parents whose children had not self-harmed. The use of thematic analysis developed an insight into how parents believed parents would feel and respond to their child's self-harm. The second part explored the experience of MH professionals who have worked with parents whose children had self-harmed. Thematic analysis was used again to generate an understanding of what MH professionals felt were the issues facing parents when finding out their child had self-harmed.

The understanding developed from the research provided a multiple voiced exploration of the research questions (Heath, 2016), and gave a depth of understanding of the perceived impact

and response of parents when finding out about their child's self-harm. A staged process used by Heath (2016) to combine multiple voice research data was used as a guiding framework, to pull the two viewpoints together. Both perspectives were reviewed separately by re-reading the results gained from the individuals and focus groups. Summaries of both standpoints were written by hand, detailing the main finding from each theme. Key words or phrases were highlighted using different coloured markers which linked to the research questions they related to. These key words/phases where then mapped back to the research questions by writing them under the specific question they related to, indicating which standpoint (parents or MH professional) they were drawn from. The points where then re-written into an order which reflected a logical flow of a parent's possible journey of discovering and responding to a child's self-harm (see Appendix P).

4.1 What are the perceived issues for parents if their child self-harmed?

It was clear from both perspectives that a key issue facing parents was their lack of perceived knowledge and understanding about self-harm. This is consistent with previous research that shows that parents find it hard to understand their child's experience because of their lack of knowledge (McDonald et al., 2007; Stewart et al., 2016). The MH professionals were clear that one of the main issues facing parents was their lack of understanding about what self-harm is, and what the young person motivations for self-harming are, confusing it often with a suicide attempt. The parent view point showed that for many of the parents self-harm was unheard of when they were teenagers themselves. This complements the theory of a social vacuum of self-harm pre 1996 (Adler & Adler, 2005), with self-harm not being talked about or being given a label, which would have provided the language for people to discuss the behaviours at this time. Parents had a limited knowledge framework to draw on when discussing their knowledge of self-harm, largely based on the experiences of friends, family members or through work or studies. This corroborates Hughes et al. (2017) research which

proposed that parents would reflect on their experience in order to start to develop an understanding of their child's self-harm. Both the parents and professionals found that because of the limited knowledge of parents they were likely to be very fearful of the self-harm and considered or mistook it for a suicide attempt. This is consistent with previous research with young people saying they felt that parents and others often did not understand their self-harm, believing it to be a suicide attempt (Brown & Kimball, 2013). The parents view builds on the field of research regarding parents' fear, as they explored the additional fears that the self-harm may become habitual or used as a status symbol amongst peers, which has not be discussed in previous research.

The parent standpoint showed that there was lack of understanding about support services for parents whose children had self-harmed. This adds to McDonald et al. (2007) research findings that parents' lack of knowledge of self-harm and what to do when their child had self-harmed, is furthered by their lack of knowledge of what support is available.

4.2 How would/do parents respond to self-harm of a child?

Both the parents and MH professionals felt that the parents would have an initial overwhelming emotional response to a child's self-harm. As found in previous research the lack of understanding parents have about self-harm is a major influence in their responses of shock, fear, and panic (Kelada et al., 2016). The research confirms the understanding that the discovery of self-harm is a very traumatic and distressing experience for parents (Raphael et al., 2006; Rissanen et al., 2011), with the MH professional outlook providing further insight by drawing attention to the deep rootedness of the distress of parents witnessing their own child's self-harm, tapping into the primal human behaviour of a parent to protect their child from pain. This is consistent with the finding from previous research which highlights parents' change in behaviour following discovering self-harm. Parents want to protect their children and often

become hypervigilant, increasing their attention and focus on their child, with the desire to constantly watch over them (McDonald, O'Brien, & Jackson, 2007).

Previous research has highlighted that parents' initial reactions were highly emotional irrespective of how they found out (Ferrey et al., 2016a). The MH professionals in this study further the understanding that parents find out about their child's self-harm in a range of different ways, and *how* they find out about the self-harm influences their responses. Parents who were informed by a third party had the chance that the person informing them could provide some information and initial support at that time, as opposed to a parent who found out because the child had had a self-harm episode and were subsequently supporting their child in distress. However, it was also found, in line with other research, that for many parents the initial reaction was often a knee jerk reaction, wanting to take some control over the situation by removing the objects the child used to self-harm (Ferrey et al,. 2016a). This has provided further understanding that the ways that parents find out that their child is self-harming can influence their initial reactions and response to the situation.

Both the parents and MH professionals identified that finding out about the self-harm would lead to parents questioning everything, blaming themselves for the self-harm. It would lead them to question their sense of identity as parents and their parenting skills, with many of parents stating they would question how it had got to that point without them being aware, feeling guilty that it had got to that point and they had not seen it. This complements Raphael et al.'s (2006) research findings that parents felt they were to blame for their child's self-harm, feeling guilt that they had not known or stopped their child, creating a sense that they were a failure.

There was agreement across the MH professionals and parents that the majority of parents would want and would seek help on discovering their child's self-harm. As a result of the parents' lack of understanding of support services, they initially said they would use the internet to amass a broad range of information. The internet is seen a "first point of reference" (Plantin & Daneback, 2009, p. 7) for parents when wanting to find out health related

information, and previous research has found that this is true for self-harm, with the objective to gain knowledge to help to gain an understanding (Hughes et al., 2017). Plantin & Danback (2009) literature review of parents' use of the internet for information and support found that the majority of parents did go online to search for information. One of reasons cited within the review was the ability of parents to remain anonymous whilst seeking information. Hughes et al.'s (2017) research suggested it was important to the parents that the websites were legitimate. Parents felt that the self-harm would be too difficult to deal with on their own, and they would want support quickly from a MH professional who they considered to be an expert. This finding is in disagreement with Oldershaw et al.'s (2008) finding that parents delay getting help until there was an accumulation of problems. Similar findings to Oldershaw et al. (2008) have been found by Boulter & Rickwood (2013) research into parents' experience of seeking help for their child with a mental condition, finding that parents were most likely to seek help when their child's mental health difficulties persisted or when the child was struggling with a number of different issues.

The ultimate goal for the parents is for the child's self-harm to stop and the parents conceptualised recovery from self-harm as the full cessation of self-harming. They saw this as a mission with an overriding sense of urgency. The MH professionals however saw recovery as more of a journey and understood that this might take some time and that the parents would need to go at the child's pace. The desire from parents for the young person to stop self-harming was also found by Hughes et al. (2017), in their study with parents of children who had self-harmed.

There was an inconsistency within the parents interviewed regarding whether they believed a parent would feel differently about their child's self-harm over time. The parents were split into two groups, one which believed their fear would never go away and they would always be worried that the child would self-harm and the second group, who felt that with the right support their fears would reduce. The inconsistency has also been seen in previous research with parents of children who had self-harmed. Rissanen et al. (2009) found that parents of children

who had self-harmed viewed their child's future as positive and hoped they would develop ways to cope. Hughes et al. (2017) in addition found that as parents gained a better understanding of the self-harm they were able to develop a new way of making sense of the situation, which helped them to think towards the future. The parents' perspective highlighted that changes in their feelings about the self-harm would be linked, over time, to how the child was progressing in their recovery, explaining they would feel frustrated if it took longer than they expected. This corroborates Ferrey et al.'s (2011a) research, which found that where the self-harmed carried on over a long period of time, parents became worn down and feelings of annoyance were cited.

4.3 What support needs do parents need or want?

Previous research found that parents' feelings of helplessness was intensified by their perceived lack of information and help from professional services (Raphael et al., 2006). Both viewpoints expressed the wishes of parents to gain support from MH professionals. Associated with the overriding desire for the child's self-harm to stop, both outlooks found that parents wanted strategies they could use and MH professionals saw it as part of their role to provide parents with these strategies. This is consistent with previous research with parents of children who had self-harmed who wanted practical suggestions on how they could handle their child's self-harm (Byrne, 2008) and parents had felt that the practical strategies were as important as treatment interventions for their child (Stewart et al., 2016). Although the overriding wish for the parents was for the child's self-harm to stop, they were also reflective that they would want help for their child and they wanted the support to provide them with hope that their child would get better. The parents would want to see progress and to be re-assured that they had chosen the right treatment for their child, highlighting the importance of feedback and communication between the parents and MH professionals.

Both perspectives highlighted the wants of parents for reassurance and confidence that they were doing the right thing. The MH professionals provided an understanding that the parents' lack of understanding and knowledge of self-harm meant that they wanted MH professionals to reassure them that they were taking the right actions to help their child and to build their confidence to deal with the situation. This echoed previous research which explained that parents doubt their own ability to be able to handle future self-harm episodes (Arbuthnott, & Lewis, 2015; Raphael et al., 2006). The MH professionals viewed that it was part of their role to act as scaffolding for the parents so the parent/child relationship could provide a source of resilience to the child.

The parents felt that their child would need some form of help and felt that it was important for there to be someone to listen to their child. They felt they would require the person helping their child to have experience of self-harm. Rissanen et al. (2013) highlighted in their clinical implication from their study the importance of people working with young people, including health professionals and teachers, having information and knowledge of self-harm. The parents would want to see progress with the support provided to their child and would want reassurance that they had chosen the right help for their child. The parents spoke about their concerns about the possibility of waiting lists for support services and if a child had to wait for support, they voiced concern that the child could get worse during this time period. This is echoed by Byrne et al.'s (2008) research with parents of children who had self-harmed, reporting that they lived in fear that their child would self-harm again whilst waiting for treatment. This reinforces the view that parents desire professional support for their child, and that this desire is driven by their fear of what will happen to their child if they cannot access this support.

The MH professional viewpoint provides additional evidence regarding the importance of involving parents and the whole family in the treatment provided to the young person, explaining that this would enable support to continue outside of the therapeutic sessions. They explained that it provided the young person with someone they can turn to at the times they

felt like self-harming. This adds to a number of existing studies which have spoken about the importance of parents working alongside professionals to aid the therapeutic process and providing support to the young person at home (Arbuthnott, & Lewis, 2015; Raphael et al., 2006). This is not a new theory and was first spoken about over 20 years ago, in relation to support for suicidal young people (Morgan et al., 1994 as cited in Raphael et al., 2006). Raphael et al. (2006) research within a clinical setting argued that parents' involvement in a child's recovery was critical in preventing further episodes. This research therefore highlights that parental involvement can have a significant impact on decreasing a young person's self-harm, and also the importance of communication between MH professionals and parents.

A stark difference between the parents and the MH professionals within the research, was that MH professionals viewed that one of their main roles was to provide education to parents about what self-harm is and is not. The MH professionals wanted to provide education about why a young person would self-harm including helping parents to understand that the self-harm was a coping strategy and not necessarily a suicide attempt. The parents did not discuss the broader need for education about self-harm in such detail and were more focused on the knowledge to develop strategies to help their child to stop self-harming. The MH professionals included strategies within the education, but took a wider view and felt that the more parents understood their child's self-harm the less likely they were to react from a position of fear. This is consistent with previous research which highlighted the need for MH professionals to provide accurate information about self-harm, the motivations of why a young person would self-harm and strategies to be used by parents to support the young person (Ferrey et al., 2016b; Kelada et al., 2016; McDonald et al., 2007; Rissanen et al., 2009; Stewart et al., 2016). This also complements the findings of Rissanen et al. (2009) who highlighted the need for professionals to provide accurate information when they proposed that one of the key factors which facilitated parents to help their child was their understanding of self-harm. It is clear that both parents and MH professionals view a significant part of the MH professionals' role to be providing accurate information to parents, though the MH professionals have a wider view

of the nature of this information, with parents being more focussed on the strategies to stop the self-harm. This shows the difference between their view points.

In addition, MH professionals also considered another main role to be to aid improved communication, the relationship, and the bond between the parents and their child. The MH professionals felt that both parents and child did not know how to speak to each other about what was happening. The MH professionals felt that disclosure of self-harm provided an opportunity to parents to start a conversation with their child which could go on to improve their relationship as well as aid the child in their recovery. This agrees with the research of Kalada et al. (2016) with parents of children who had self-harmed, who expressed that they felt that their relationship with their child had strengthened after the self-harm disclosure because of their increased communication and the help they provided to their child. Therefore the professionals felt that self-harm could provide an opportunity for parents to improve the relationship with their child.

Peer support groups were identified by the MH professionals as an important way to provide support to parents. The MH professionals believed that the parents could provide scaffolding to each other by sharing their own experiences and the strategies that they had tried, providing a way for parents' feelings to be validated and therefore leaving them feeling less alone. The National Institute for Health and Clinical Excellence (NICE) have approved parenting support programmes as a standard treatment for young people with conduct disorders (Byrne et al., 2008) and although parents programmes as part of the treatment of a young person's self-harm has not yet been advocated by NICE (Nice.org.uk, 2013), research to explore their benefit has started, such as the SPACE programme (Morgan et al., 2013, Power et al., 2009). Within the last 10 years there has been a number of studies which have cited parent support groups as helpful in the treatment for young people who self-harmed (Ferrey et al., 2016a), postulating that they could assist with decreasing isolation and distress experienced by parents (Arbuthnott, & Lewis, 2015; McDonald et al., 2007) in the form of social support, gaining information and strategies they can use to help their child (Ferrey et al., 2016a; Morgan

et al., 2013). It has been argued that parents could find it comforting to hear the experiences of other parents (Byrne et al., 2008; Ferrey et al., 2016a; Kelada et al., 2016) and these relationships between parents have been proposed to be reciprocally supportive (Hughes et al., 2017). This was echoed by the MH professionals in this research, who spoke about the relief that parents expressed when they found out that other parents were having similar experiences with their children. Peer support groups were seen to be an opportunity for parents to gain beneficial support.

Strength and Limitations

This project used a multiple methods approach with two different participant groups, which had strength and limitations. This project paid attention to the voices of both mothers and fathers. A father's voice has been limited in some of the previous research with parents regarding self-harm, with generally a higher sample mothers included (Ferrey et al., 2016a; Ferrey et al., 2016b; Kelada et al., 2016; McDonald et al., 2007; Stewart et al., 2016). This is important because previous research with parents of children who have self-harmed has found that sometimes fathers and mothers take a different view on the strategies they wish to use to support their child (Ferrey et al., 2016a).

Additionally, this research addresses a gap within the field of research of self-harm to include parents of children who have not self-harmed, providing an insight into their knowledge and how they may go about seeking information and help. This research explores how parents' conceptualise self-harm *prior* to direct experience of their child self-harming.

Despite these strengths, there are also limitations to this project. Research has highlighted the distressing nature of self-harm for parents (Kelada et al., 2016; McDonald et al., 2007; Raphael et al., 2006). There may be a population of parents who did not select to take part in this research because of the potentially distressing nature of discussing self-harm. They may have considered it to be a subject which they would feel uncomfortable to discuss in detail.

The MH professionals also self-selected to take part in the research and this may have introduced a bias into the research towards professionals who were more confident in dealing with self-harm. MH professionals who were less confident with dealing with self-harm may have not come forward for the research because they did not deem themselves to have enough knowledge. This limitation has been cited in previous research with counsellors who worked with students who self-harm, proposing that those who were less aware of self-harm would be less likely to take part in the research (Roberts-Dobie & Donatelle, 2007).

As the researcher also worked with the potential MH professional participants some professionals may have been deterred from participating, worried that their standard of work may have been judged. In additional the MH professionals were recruited from just one community based organisation, and therefore this research does not take into account the views of MH professionals from other community based organisations which maybe have different policies and procedures for dealing with self-harm. The research also did not include MH professionals who work within a clinical setting such as the Child and Adolescents Mental Health Services or on an inpatient ward within a hospital (Byrne et al., 2008; Morgan et al., 2013; Oldershaw et al., 2008; Raphael, Clarke, & Kumar, 2006), who again may have different experiences from those working in a community setting.

Directions for future research

This project has indicated a belief that parents whose children self-harm would want to seek information and support. Additional research is needed to understand the specific process which parents would follow, tracking and exploring their decisions and motivations at each stage, including what tools they use at which stage, such as the use of the internet. This would provide a greater understanding of what questions and needs parents have at the initial stages of finding out about their child's self-harm and where they initially turn to for this support.

This project also highlighted that whilst the parents felt under-prepared in terms of knowledge and support, they welcomed the growth in awareness around self-harm. Further research could examine the support information already available to parents, and evaluate its efficacy in providing information and support.

The benefits of peer support groups for parents of children who have self-harmed have been highlighted by the MH professionals, in particular. Research into this type of support is in its infancy within the field of self-harm (Morgan et al., 2013, Power et al., 2009), with only a small number of research studies recommending the provision of peer support groups to parents (Ferrey et al., 2016a; Ferrey et al., 2016b; Raphael et al., 2006; McDonald et al., 2007). This project adds to the evidence of the benefits of this type of support, though more research could be done to explore the uses and impact of these groups.

Conclusions

Self-harm for young people has been considered to be a significant health concern (Byrne et al., 2008) and is understood to be typical amongst young people (Hawton et al., 2002). A key issue facing parents is their lack of knowledge and understanding about self-harm, often confusing it with a suicide attempt. Parents also have a lack of understanding about what support could help them if their child self-harmed and where they would go for that support, following discovery of the self-harm. Parents find out about their child's self-harm through a range of different ways (Ferrey et al., 2016b) and, on finding out, they experience an array of overwhelming emotions. How parents find out about their child's self-harm can influence how they respond to their child. If the self-harm is reported by a third party such as a school or a MH professional, it provides the opportunity for the person who is disclosing the self-harm to provide some initial information and guidance to the parent. There is a desire by parents to gain strategies of how they can help their child. Parents often want some control over their child's self-harm and want the self-harm to cease, and see this as a sign of their child's recovery, whereas MH professionals are more likely to see the child's recovery as a journey which may take a period of time. MH professionals see themselves as having a wider role providing both strategies and also education regarding self-harm. MH professionals wish to provide education about what self-harm is, with the objective that parents will respond less from a position of fear if they have greater understanding of self-harm. Parent support groups have been identified as an important tool to support parents and reduce feelings of isolation. There is a need for further research to focus in more detail on the processes which parents follow to seek information and help regarding self-harm. In addition the impact of peer support for parents of children who self-harm is an avenue for future research in both community and clinical settings.

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Appendices

Staff / Office Use Only

DOPEC NUMBER: *Click here to enter text.*

Umbrella project DOPEC number (staff) ***Click here to enter text.***

APPLICANT SURNAME Ruck

APPLICANT:	**UG ☐**	**PGT ☒**	**PGR ☐**	**Staff ☐**
***REVIEW PROCESS*:**	**Accelerated ☐**	**Full ☒**		
APPLICATION STATUS:	**New application ☒**	**Major amendment ☐**	**Resubmission ☐**	
APPLICATION FOR:	**Dissertation ☒**	**Teaching ☐**	**Research & publication ☒**	
***ATTTENDENCE AT HEALTH & SAFETY BRIEFING*:**	**Yes ☒**	**No ☐**	**N/A ☐**	
INCLUSION OF RISK ASSESSMENT FORM:	**Yes ☐**	**No ☐**	**N/A ☐**	

NOTES ON THE ROLE AND FUNCTION OF THE DEPARTMENT OF PSYCHOLOGY ETHICS COMMITTEE.

- *All decisions of the committee are based on the application form and reviewers comments ONLY. Forms should be as detailed and clear as possible. Verbal discussions are not considered as part of the application or review process.*
- *The review process strictly adheres to the University of Chester Research Governance Handbook and the BPS Code of Ethics.*
- *The decision of the committee is final. If you are a UG, PGT or PGR student you should discuss the decision of the committee with your supervisor. If you are a member of staff you may contact the chair of the committee for further clarification.*

Before completing the form researchers are expected to familiarise themselves with the regulatory codes and codes of conduct and ethics relevant to their areas of research, including those of relevant professional organisations and ensure that research which they propose is designed to comply with such codes.

Department of Psychology Ethical Approval for Research: Procedural Guidelines.

University of Chester Research Governance Handbook

http://ganymede2.chester.ac.uk/view.php?title_id=522471

BPS Code of Ethics

http://www.bps.org.uk/system/files/Public%20files/bps_code_of_ethics_2009.pdf

BPS Code of Human Research Ethics

http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf

BPS Guidelines for Internet-mediated Research

http://www.bps.org.uk/system/files/Public%20files/inf206-guidelines-for-internet-mediated-research.pdf

BPS Research Guidelines and Policy Documents

http://www.bps.org.uk/publications/policy-and-guidelines/research-guidelines-policy-documents/research-guidelines-poli

Any queries email: n.davies@chester.ac.uk or psychology_ethics@chester.ac.uk

CHECK LIST.

Please complete the form below indicating attached materials. Prior to submission supervisors must confirm that they have reviewed the application by completing the supervisors column.

Notes: Students to indicate where information is found, supervisor to confirm by ticking green column	**Supervisor confirmation**	**Information. sheet**	**Letter**	**Email**	**Email info. page**	**Consent Form**	**PowerPoint**	**N/A**
Brief details about the purpose of the study	X	X	☐	X	☐	☐	☐	☐
Contact details for further information	X	☐	☐	X	☐	☐	☐	☐
Explanation of how and why participant has been chosen	X	X	☐	☐	☐	☐	☐	☐

Notification that materials/interviews are not diagnostic tools/therapy or used for staff review/development purposes	X	X	☐	☐	☐	☐	☐	☐
Explanation participation is voluntary	X	X	☐	☐	☐	☐	☐	☐
Details of any incentives or compensation	X	X	☐	☐	☐	☐	☐	☐
Details of how consent will be obtained	X	X	☐	☐	☐	☐	☐	☐
If research is observational, consent to being observed	X	☐	☐	☐	☐	☐	☐	X
Details of procedure so participants are informed about what to expect	X	X	☐	☐	☐	☐	☐	☐
Details of time commitments expected	X	X	☐	☐	☐	☐	☐	☐
Details of any stimuli used	X	☐	☐	☐	☐	☐	☐	X
Explanation of right to withdraw and right to withdraw procedure	X	X	☐	☐	☐	☐	☐	☐
Option for omitting questions participant does not wish to answer	X	X	☐	☐	☐	☐	☐	☐
Procedure regarding partially completed questionnaires or interviews	X	X	☐	☐	☐	☐	☐	☐
With interviews, information regarding time limit for withdrawal	X	X	☐	☐	☐	☐	☐	☐
Details of any advantages and benefits of taking part	X	X	☐	☐	☐	☐	☐	☐
Details of any disadvantages and risks of taking part	X	X	☐	☐	☐	☐	☐	☐
Information that data will be treated with full confidentiality and that, if	X	X	☐	☐	☐	☐	☐	☐

published, those data will not be identifiable as theirs								
Debriefing details	X	X	☐	☐	☐	☐	☐	☐
Dissemination information	X	X	☐	☐	☐	☐	☐	☐
Further information (relevant literature; support networks etc)	X	X	☐	☐	☐	☐	☐	☐

Supervisor Signature: Hannah Heard. ***Date :24/01/2018***

University of Chester

DEPARTMENT OF PSYCHOLOGY APPLICATION TO DEPARTMENTAL ETHICS COMMITTEE

WHEN COMPLETING THE FORM PLEASE REFER TO THE DOP ETHICS PROCEDURAL GUIDELINES HANDBOOK.
UG AND PGT STUDENTS CAN ACCESS A COPY ON THEIR RELEVANT MOODLE PAGE.
PGR AND STAFF SHOULD CONTACT n.davies@chester.ac.uk or psychology_ethics@chester.ac.uk

1. Working title of the study

Notes: The title should be a single sentence

What are the issues facing parents of children who self-harm?: A multiple qualitative method approach

2. Applicant name and contact details

Notes: The primary applicant is the name of the person who has overall responsibility for the study. Include their appointment or position held and their qualifications. For studies where students

and/or research assistants will undertake the research, the primary applicant is the student (UG, PGT, PGR) and supervisor is the co-applicant.

Samantha Ruck. 07810 481390. 1622346@chester.ac.uk

3. Co-applicants

Notes: List the names of all researchers involved in the study. Include their appointment or position held and their qualifications

Dr Hannah Heath

4. Start and end dates of the study

Notes: The title should be a single sentence

January 2018 to September 2018

5. Is this project subject to external funding?

Notes: Please provide details of the funding body, grant application and PI.

No

6. Briefly describe the purpose and rational of the research

Notes: (Maximum 300 words). In writing the rationale make sure that the research proposed is grounded in relevant literature, and the hypotheses emerge from recent research and are logically structured.

If this application is for a PGR/Staff funded project please attach any detailed research proposals as appropriate.

Self-harm is typical amongst adolescents; with studies reporting that 10 to 15% of young people have at some point self-harmed (Hawton, Rodham, Evans & Weatherall, 2002; Doyle, Treacy & Sheridan, 2015).

The discovery by a parent that their child is self-harming is extremely distressing (Raphael, Clarke, & Kumar, 2006). Parents experience overwhelming emotions of guilt and shame (McDonald, O'Brien, & Jackson, 2007). Not knowing how to respond or support their child (Oldershaw, Richards, Simic, & Schmidt, 2008), they feel unequipped with the skills they believe are needed to support their child (Kalada, Hasking & Melvin 2016).

Parents report that their relationship with their child changes following discovery of the self-harming (Kelada et al., 2016) and the functioning of the family unit is impacted (McDonald et al., 2007; Raphael et al., 2006; Oldershaw et al,. 2008; Kelada et al., 2016).

Studies have highlighted negative experiences by parents of professionals, where they have felt that the professional blames them for the child's self-harm and this has discouraged them or stopped them from seeking help from professionals in the future (Lindgren, Aström, Graneheim, Umeå, Institutionen för, & Medicinska, 2010; Raphael et al,. 2006).

McDonald et al., (2007) reasoned that professionals working with parents of children who self-harmed can normalise the feeling of shame or guilt, and providing psychoeducation about why young people self-harm. It is fundamental that professionals working with the family are non-judgemental and empathetic (Kelada, 2016).

To date, research has established that parents of those who self-harm are a vulnerable population, yet, we know little about their own help-seeking preferences. Drawing on the experiences of parents, as well as the expertise and experiences of wellbeing workers and counsellors, we hope to get a better idea of the support needs for parents. Multiple qualitative perspectives research is limited in the context of self-harm, particularly around research concerning parents. The aim of this project is to gain a better understanding of what support is needed by parents at a challenging time in order

to answer the research question, *What are the issues facing parents when seeking support for their child's self-harm, through dedicated services?*

7a. Describe the methods and procedures of the study

Notes: (Maximum 500 words) Attach any relevant material (questionnaires, supporting information etc.) as appendices and summarise them briefly here (e.g. Cognitive Failures Questionnaire: a standardised self-report measure on the frequency of everyday cognitive slips). Do not merely list the names of measures and/or their acronyms. Include information about any interventions, interview schedules, duration, order and frequency of assessments. It should be clear exactly what will happen to participants. If this is a media based study describe and list materials include links and sampling procedure.

A multi-method qualitative design will be used, including semi-structured interviews with parents, and focus groups with professionals working with young people (comprising of counsellors and wellbeing workers).

Interviews with parents

Semi-structured interviews will be held with parents who children have not self-harmed and therefore not sought help in a bid to understand their understandings of the help-seeking process, to identify how they would seek help, and to explore any barriers in to help-seeking .

Interviews will also be held with parents children (aged 16+) have self-harmed in the past but are no longer self-harming, to understand their experiences of the support, or lack of support, they received/accessed, how they accessed the support, and the process of seeking support.

Participants will be recruited from the RPS system (appendix H), and postering around campus (appendix G).

Interested participants will be emailed thanking them for their enquiry and if they are interested in taking part asking them to confirm which interview group they would fit into (appendix I) including the information sheet (appendix J) providing more detail to help them decide about participating

I aim to recruit 10-15 parents in total. The interviews will be held in private locations, such as at Visyon or on campus and will last up to an hour.

At the start of the interview, participants will complete a consent form (appendix M) and a demographics sheet (appendix N).

The applicant will employ a semi-structured interview schedule (appendix K & L).

The interviews will be audio recorded and subsequently transcribed verbatim. Identifiable information (e.g. names and places) will be anonymised during transcription. Participants will have been encouraged to choose a pseudonym during the interview.

On completion of the interview, all participants will be thanked and given an information sheet detailing local and national sources of relevant support (appendix N).

Focus group with Visyon workers

A focus group will be held with the early help team (Wellbeing Workers and counsellors). This team provides support with emotional wellbeing and mental health through either mentoring or counselling services. This focus group will explore their experiences of working with parents and young people. What young people report as being an issue with their parents following them discovering that they have self-harmed. What they believe both find most helpful or not helpful.

Participants will be recruited from the applicant's workplace via email (appendix A) (a confirmation letter can l be provided to the committee chair by the CEO/board of trustees once ethical approval has been granted). Interested participants will respond to the email and in response the applicant will send an email (appendix B) including the information sheet (appendix C) providing more detail to help them decide about participating.

We aim to conduct one focus group, with around 6 participants in. The focus groups will be held at Visyon, and last up to an hour and a half.

At the start of the focus group, participants will complete a consent form (appendix D) and a demographics sheet (appendix D).

The focus group leader will employ a semi-structured interview schedule (appendix E).

The group discussion will be audio recorded and subsequently transcribed verbatim. Identifiable information (e.g. names and places) will be anonymised during transcription. Participants will have been encouraged to choose a pseudonym during the focus group.

On completion of the group discussion, all participants will be thanked and given an information sheet detailing local and national sources of relevant support (appendix F).

Analysis

Once the interviews and focus group have been transcribed, the data will be analysed using the six stages of Thematic Analysis (Braun & Clarke, 2006).

7b. Provide details of your contingency plan

Notes: Please briefly describe your contingency plan. (100 words)

Should recruitment be slow, further focus groups will be held with support organisations.

8. Provide details of the previous experience of the procedures by the person conducting the study.

Notes: Say who will be undertaking the procedures involved and what training and/or experience they have. If supervision is necessary, indicate who will provide it.

I, Samantha Ruck will be undertaking the individual interviews with parents and the focus groups with professionals. I am the Therapeutic Services Manager at Visyon, a children and young person mental health charity. I regularly speak to parents when they have just found out that their children have self-harmed. I provide psychoeducation regarding self-harm, and signpost onto further support. I have monthly clinical supervision, which I can discuss any difficult cases and to ensure I maintain my own wellbeing within my professional role. I am completing the Masters course part time and completed PS7301 Researching Thought and Behaviour and PS7302 Practical Skills for Research last year. I have also previously worked as a Market Researcher within the banking industry and part of this role focus groups were carried out regarding banking product and services.

Dr Hannah Heath has also got experience in qualitative data collection and analysis methods.

9. Describe the ethical issues raised by this study and discuss the measures taken to address them.

Notes: Describe any discomfort or inconvenience that participants may experience. Include information about procedures that for some people could be physically stressful or might impact on the safety of participants, e.g. interviews, probing questions, noise levels, visual stimuli, equipment; or that for some people could be psychologically stressful, e.g. mood induction procedures, tasks with high failure rate, please include your distress protocol. Discuss any issues of anonymity and confidentiality as they relate to your study, refer to ethics handbook and guidance notes at the end of the form. If animal based include ethical issues relating to observation.

Parents may become distressed when talking, and answering the interview questions in detail about their children's' self-harm and their experiences of this. I will provide parents with a signposting sheet with details of a range of support organisation for their own wellbeing, the family's wellbeing and specific support linked to self-harm.

If a safeguarding concern regarding a young person was raised during the interviews, I would discuss my concern with the parent and Dr Hannah Health and if required raise my concern with the relevant local authority through their specific reporting systems.

Anonymity and confidentiality will be maintained by use of coding for participants when writing up the interviews, and reporting in the dissertation. The transcripts of the interview will be held securely in password protected documents. Recording of the interviews will be taken and only kept to support the transcribing of the interviews. Once this has been completed the recordings of the interviews will be deleted.

Staff may become distressed when talking about the impact they witness on client when they self-harm and the distress which parents experience. A de-brief will be carried out following the focus group for members to check in how they feel. Visyon line managers will be made aware of which staff

are taking place in the focus group so a one to one check in can be completed with the team member at their next supervision session. All staff member are support in their everyday work at Visyon to deal with difficult and emotive situations. All staff members have line management support and external clinical supervision to ensure they maintain their wellbeing within their role.

If any safeguarding concerns regarding a young person safety was raised in the focus groups, the concern would be reported through Visyon's safeguarding policy processes.

10. Describe the participants of the study.

Notes: Describe the groups of participants that will be recruited and the principal eligibility criteria and ineligibility criteria. Make clear how many participants you plan to recruit into the study in total.

Click here to enter text.

1. 5-7 parents of children aged 16+ who have not self-harmed.
2. 5-8 number of parents whose children aged 16+ have previously self-harmed, but are not currently.
3. A focus group with about 6 Visyon professionals (Wellbeing workers and counsellors) who work directly with young people, and who have experience of working with at least one client who has self-harmed in the last year.

11. Describe the participant recruitment procedures for the study.

Notes: Gives details of how potential participants will be identified or recruited, please list any social media platforms that you will use and the message. Include all other advertising materials (posters, emails, letters, verbal script etc.) as appendices and refer to them as appropriate. Describe any screening examinations. If it serves to explain the procedures better, include as an appendix a flow chart and refer to it.

Parents will be recruited through the RPS system (appendix H), and posters placed around University (appendix G). Visyon staff will be emailed through the work mailing address (appendix A)

12. Describe the procedures to obtain informed consent

*Notes: Describe when consent will be obtained. If consent is from **adult participants**, give details of who will take consent and how it will be done. If you plan to seek informed consent from **vulnerable***

groups *(e.g. people with learning difficulties, victims of crime), say how you will ensure that consent is voluntary and fully informed.*

If you are recruiting ***children or young adults*** *(aged under 18 years) specify the age-range of participants and describe the arrangements for seeking informed consent from a person with parental responsibility. If you intend to provide children under 16 with information about the study and seek agreement, outline how this process will vary according to their age and level of understanding.*

How long will you allow potential participants to decide whether or not to take part? What arrangements have been made for people who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?

If you are not obtaining consent, explain why not.

Obtaining consent will take place before the interview starts. The details of the project will be presented in an information sheet (appendix C & J) via email and also in the interview. In the interview, participants will be asked to sign a consent form (appendix D & M).

13. Will consent be written?

Yes ☒ *No* ☐

Notes: If ***yes****, include a consent form as an appendix. If* ***no****, describe and justify an alternative procedure (verbal, electronic etc.) in the space below.*

Guidance on how to draft Participant Information sheet and Consent form can be found on PS6001 Moodle space and in the Handbook.

See appendix D & M

14. Describe the information given to participants. Indicate if and why any information on procedures or purpose of the study will be withheld.

Notes: Include an Information Sheet that sets out the purpose of the study and what will be required of the participant as appendices and refer to it as appropriate. If any information is to be withheld, justify this decision. More than one Information Sheet may be necessary.

No information will be withheld from participants.

15. Indicate if any personally identifiable information is to be made available beyond the research team. (eg: a report to an organisation)

Notes: If so, indicate to whom and describe how confidentiality and anonymity will be maintained at all stages.

No personally identifiable information will be made available beyond the research team.

16. Describe any payments, expenses or other benefits and inducements offered to participants.

Notes: Give details. If it is monetary say how much, how it will be paid and on what basis is the amount determined. Indicate RPS credits.

No payments will be made.

17. Describe the information about the investigation given to participants at the end of the study.

Notes: Give details of debriefings, ways of alleviating any distress that might be caused by the study and ways of dealing with any clinical problem that may arise relating to the focus of the study.

Participants will be given the information sheet to take away with them (appendix F & N)

18. Describe data security arrangements for during and after the study.

Notes: Digital data stored on a computer requires compliance with the Data Protection Act; indicate if you have discussed this with your supervisor and describe any special circumstances that have been identified from that discussion. Say who will have access to participants' personal data and for how long personal data will be stored or accessed after the study has ended.

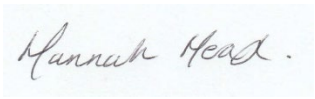
All data will be digital and will be stored on a password protected computers and an encrypted USB hard drives. This complies with the Data Protection Act. Data will be stored indefinitely and participants will be advised of this in the information given at the start of the study. This complies with some journals requesting data to be submitted for others to analyse.

SIGNATURES OF THE RESEARCH TEAM

Notes: The primary applicant and all co-applicants must sign and date the form. Scanned or electronic signatures are acceptable.

Hannah Heath

24/01/2018



Samantha Ruck

01/02/2018

ETHICS COMMITTEE DATE Click here to enter a date.

☐ ACCEPTABLE

You may now commence data collection subject to approval from any relevant external agencies.

CHAIRS COMMENTS

☐ Read and review all reviewers comments

DATA COLLECTION IS NOT PERMISSABLE UNDER THE FOLLOWING 3 CONDITIONS. Please address the issues indicated.

☐ ACCEPTABLE SUBJECT TO SUBMISSION OF AMENDMENT FORM

UG and PG students should discuss any recommendations with their supervisors.

☐ ACCEPTABLE SUBJECT TO CONDITIONS OF CHAIR

Resubmit application for full review after addressing the issues described, ensuring you have indicated on the front page of the form that this is a resubmission.

☐ REVISE AND RESUBMIT

Resubmit application for full review ensuring you have indicated on the front page of the form that this is a resubmission

SIGNATURE: Click here to enter text.

University of Chester

UNIVERSITY OF CHESTER, DEPARTMENT OF PSYCHOLOGY

APPLICATION FOR ETHICAL APPROVAL AMENDMENT FORM

A) Applicant and personnel

Applicant: *Samantha Ruck*

Project title: *What are the issues facing parents of children who self-harm? A multiple qualitative method approach.*

Applicant status: ☐ Staff → Go to Section B ☐PGR ☐Undergraduate ☒Postgraduate taught

Supervisor: *Hannah Heath*

B) Declaration

1. ☒ I have submitted an application for ethical approval to the Department of Psychology Ethics Committee and I am required to make the following amendments to my application.
   List the recommendations of the committee.

   1. Clarification of distressed protocol.

   2. Pointed out to participants that the study is for research only and not diagnostic purposes.

   3. Advisable to state on the PIS if participants feel this will increase their level of distress they shouldn't take part

   4. Should be made clear that the study is being conducted by a MSC student.

   5. Make clear that no support organizations will receive or have access to any data.

   6. RPS credits need to be listed on the PIS

   Describe how you have addressed these requirements.

   1. It is unlikely that a participant will become distressed. However, should participants show signs of distress, they will be asked if they wish the focus group or individual interview to pause whilst they compose themselves. Should they wish to withdraw, they will be given the resource sheet with details of local and national support services. These support services include the individuals GP, Samaritans, Mind and Harmless for Visyon staff members, and in addition Family Lives and Young Mind Parent Helpline for parents.

   2. "The study is for research only and not for diagnostic purposes" has been added to the Participant Information Sheets (PIS) for both the focus group and individual interviews.

   3. This statement has been added to both PIS's

   4. A statement has been added to cover this point in the What is the purpose of the study sections of the PIS's

   5. A statement has been added to cover this point in the What is the purpose of the study sections of the PIS's, and a letter has been provided by Visyon CEO confirming that he is happy for the research to take place and confirms they will not have access to the data gathered from the staff member focus groups

   6. RPS credits have been listed on the PIS. Supervisors details has been added to poster.

2. ☒ I have submitted an application for ethical approval to the Department of Psychology Ethics Committee that was approved on 22/02/2018

I wish the committee to consider the following amendments I would like to make to the research plan (attach the original approved application form)

There was a typo on appendix M it said – I under that the focus group discussion will be audio recorded via a Dictaphone. This has been changed to – I understand that the interview will be audio recorded via a Dictaphone.

I wish to add to the contingency plan if I struggle to recruit 6 Visyon workers to attend one focus group due to different working patterns and times when they are available, I will hold multiple focus groups.

☐ I am a member of staff. **Signed:** _____ **Date:** Click here to enter a date.
Print the amendment form on BLUE PAPER and submit to the Dept. Office
☐ I am an UG/PGT/PGR student. I have discussed any amendments with my project supervisor.
Print the amendment form on BLUE PAPER and submit to the Dept. Office

Signed: _____ **(Lead Applicant)** Date: Click here to enter a date.

Supervisor comments:
I have discussed the recommendations of the committee with the applicant and I am satisfied they have met the stated requirements./I support the amendments to the research plan. (delete as appropriate)
☐ Yes Sign and date the form ☐ No Comments: *Click here to enter text.*

Signed: _____ **(Supervisor)** Date: Click here to enter a date.

COMMITTEE COMMENTS:

☐ **ACCEPTABLE: You may now commence with data collection subject to approval from any relevant external agencies.**

DATA COLLECTION IS NOT PERMISSABLE UNDER THESE CONDITIONS

☐ **ACCEPTABLE SUBJECT TO SUBMISSION OF FURTHER AMENDMENT FORM.**

☐ **Acceptable subject to conditions listed by chair. Discuss conditions highlighted with supervisor and submit ethics application amendment form direct to office.**

☐ **Acceptable subject to conditions listed by chair: Submit ethics application amendment form direct to office.**

Signed: _____ Date: Click here to enter a date.

University of Chester

UNIVERSITY OF CHESTER, DEPARTMENT OF PSYCHOLOGY

APPLICATION FOR ETHICAL APPROVAL AMENDMENT FORM

C) Applicant and personnel

Applicant: *Samantha Ruck*

Project title: *What are the issues facing parents of children who self-harm? A multiple qualitative method approach.*

Applicant status: ☐ Staff → Go to Section B ☐PGR ☐Undergraduate ☒Postgraduate taught

Supervisor: *Hannah Heath*

D) Declaration

3. ☐ I have submitted an application for ethical approval to the Department of Psychology Ethics Committee and I am required to make the following amendments to my application.
   List the recommendations of the committee.

   Describe how you have addressed these requirements.

4. ☒ I have submitted an application for ethical approval to the Department of Psychology Ethics Committee that was approved on 22/02/2018
   I wish the committee to consider the following amendments I would like to make to the research plan (attach the original approved application form)
   Recruitment for one to one interviews with parents has been sluggish and I have had no response from my posters and PRS advert. I therefore wish to extend my recruitment and advertise via Facebook to my contacts. Facebook advert included. I have included an updated parent information sheet because the PRS credits will not be relevant.
   I wish to add to the contingency plan, if I am unable to recruit the required number of parents for interview, to carry a document analysis of 10 factsheets or support websites/ tools for parents. They will be selected using the search terms such as "self-harm support information", "self-harm information for parents". I have included an example of family lives support information for parents as an example. Once identified, the websites/factsheets/tools will be either downloaded or copied into a word document. Once all factsheets and support tools have been collected they will be analysed using Thematic Analysis (Braun & Clarke, 2006).

☐ I am a member of staff. **Signed:** _____ **Date:** Click here to enter a date.
Print the amendment form on BLUE PAPER and submit to the Dept. Office
☐ I am an UG/PGT/PGR student. I have discussed any amendments with my project supervisor.
Print the amendment form on BLUE PAPER and submit to the Dept. Office

Signed: _____ **(Lead Applicant)** Date: Click here to enter a date.

Supervisor comments:
I have discussed the recommendations of the committee with the applicant and I am satisfied they have met the stated requirements./I support the amendments to the research plan. (delete as appropriate)

☐ Yes Sign and date the form ☐ No Comments: *Click here to enter text.*

Signed: _____ **(Supervisor)** **Date:** Click here to enter a date.

COMMITTEE COMMENTS:

☐ **ACCEPTABLE: You may now commence with data collection subject to approval from any relevant external agencies.**

DATA COLLECTION IS NOT PERMISSABLE UNDER THESE CONDITIONS

☐ **ACCEPTABLE SUBJECT TO SUBMISSION OF FURTHER AMENDMENT FORM.**

☐ **Acceptable subject to conditions listed by chair. Discuss conditions highlighted with supervisor and submit ethics application amendment form direct to office.**

☐ **Acceptable subject to conditions listed by chair: Submit ethics application amendment form direct to office.**

Signed: _____ Date: Click here to enter a date.

Appendix A

Email recruitment – Title of email: Exploring the experience of parents whose children self-harm, from a young person's counsellor and wellbeing worker perspective

Dear (name),

I am currently recruiting team members to take part in a focus group exploring your experience of parents whose children self harm. Looking at the impact of self-harm on parents, and if/how they support their children.

If you have experience of supporting a client(s) who self-harmed in the last year and you are interested in participating in this study, please contact me and I can forward you some more information to help you make a decision about participating.

Thank you for considering this request,

Sam

Appendix B

Email response

Re: Exploring the experience of parents whose children self-harm, from a young person's counsellor and wellbeing worker perspective

Dear (name),

Thank you for expressing your interest in taking part in the study about counsellors and well being workers experiences of parents whose children self-harm. **What will I have to do if I agree to take part?**

I will take up no more than an hour and a half of your time. You will be invited to attend a focus group to discuss your experiences of parents whose children self-harm. The focus group will have a maximum of 6 members of staff. As a group, you will be asked to discuss a series of questions about the experience of parents whose children self-harm.

The group discussion will be recorded, and later transcribed. All names and places mentioned in the discussion will be anonymised. We will keep your participation in the group confidential - the group members will be given pseudonyms and all those who take part will agree to maintain one another's confidentiality.

You can decide to leave the group discussion at any point, but your contributions up to that point *will* be included in the analysis.

Following the group discussion, all participants will be given an information sheet containing useful resources for help and support with self-harm.

Please find the attached Information Sheet which will provide you with further details about the research, including the advantages and possible disadvantages of taking part, what the study entails and your rights as a participant.

If you decide that you would like to take part, please respond to this email providing times you could be available to take part in a focus group.

If you have any queries, concerns or would like some advice regarding whether you should participate or not, you can contact me, by replying to this email.

Thanks and best wishes,

Sam

Appendix C

University of Chester

Participant Information Sheet:

Exploring the experience of parents whose children self-harm, from a young person's counsellor and wellbeing worker perspective

You are invited to participate in this research study which aims to investigate the experiences of parents whose children self-harm. Please read the following information carefully before deciding whether or not to take part.

What is the purpose of the study?

The purpose of this study is to better understand the experiences of parents whose children self-harm. This study is being complete by a MSc student. No support organisations will receive or have access to any data from the study. The results will be used for a MSc dissertation and it is intended that findings will be used for publication in academic journals and conferences.

Why have I been invited?

You have been invited because you are a staff member or volunteer and have indicated that you have knowledge and/or experience of working with young people who have self-harmed.

Do I have to take part?

Your participation in this study is entirely voluntary. You have the right to leave at any point before or during the study and refrain from answering individual questions, however please be aware that should you choose to withdraw during the focus group, all your contributions up to that point will be included. Similarly, you will not be able to withdraw your data after the focus group. If you agree to take part, you will be asked to sign a consent form. Please note that there are no right or wrong answers, and any answers you provide will not be used for diagnostic purposes.

What will I have to do if I agree to take part?

If you agree to take part, you will attend an audio recorded focus group. A maximum of six staff will discuss their experiences of the issue of clients self-harm; its impact and the issues it raised for parents trying to support their child. The group discussion will last no more than an hour

What are the possible disadvantages and risks of taking part?

We do not anticipate any disadvantages to taking part. The discussion provides an opportunity to share experiences of what is often a challenging area of work; sharing experiences can be reassuring and empowering. This research covers a sensitive topic and if you feel this will increase your level of distress we advise that you do not participate in the study. Please note that the study does not constitute therapy. The study is for research only and not for diagnostic purposes.

Will I be rewarded for my participation?

Appendix C

Whilst there are no rewards for participation, we hope that you will enjoy participating in the discussion and contributing to research in an under-explored field. We hope that our findings will result in a better understanding of the issues surrounding parents of children who self-harm.

Will my participation in the study be confidential?

Any personally identifiable data collected from you, i.e. the information that you provide in the demographics sheet, will remain confidential. The recordings of the focus group discussion will be shared in the research team, and will be stored on a password protected computer. A process of anonymisation during transcription of the recordings will ensure that any identifiable information such as names and locations is removed.

Due to the nature of the focus group, complete anonymity to those people taking part cannot be guaranteed; however, all members of the group formally agree in writing to confirm that they undertake to respect the confidentiality of others and not talk about the study outside of the setting. All discussions are to be kept broad, to ensure that no client is identifiable and client confidentiality is maintained. It is hoped that the findings will be shared for use in a published academic journal and conferences. Any publication resulting from this work will report only data that does not identify you.

Further information and contact details

If you require any further information about the study, the relevant points of contact are below:

Research Team:

Samantha Ruck Email: 1622346@chester.ac.uk

Dr Hannah Heath (University of Chester) Email: h.heath@chester.ac.uk

If you are affected by any issues raised, you may wish to contact your GP, the Samaritans (email: jo@samaritans.org, phone: 116 123), Mind (www.mind.org.uk, phone 0300 123 3393, email info@mind.org.uk) or Harmless (www.harmless.org.uk/professionals/workingWithYoungPeople)

Any concerns or complaints about the research may be sent to Professor Ros Bramwell, Head of the Department of Psychology, at r.bramwell@chester.ac.uk.

Ethical approval has been provided by the University of Chester Department of Psychology ethics committee.

Appendix D

Consent Form: Exploring the experience of parents whose children self-harm, from a young person's counsellor and wellbeing worker perspective

Please read the following statements and, if you agree, tick the corresponding box to confirm agreement:

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason by leaving the room. ☐

I understand that my data will be treated confidentially and any publication resulting from this work will report only data that does not identify me. I understand that if I withdraw from the study, any partially collected data will still be used for analysis. ☐

I understand that the discussion must remain confidential and I confirm that I will not disclose the identity of any participants or the information that they share. ☐

I will demonstrate the same level of respect towards the opinions and expressions of my peers as I would expect for my own. ☐

I understand that the research is not in the form of an examination or test and therefore, I should not refrain from expressing myself for fear of being challenged or incorrect. ☐

I understand that the focus group discussion will be audio recorded via a Dictaphone. ☐

Name

_____

Signature

_____

Date

_____

Appendix D

Demographics

Your identified gender

_____

Age

_____

Time working as a counsellor or wellbeing worker with young people (years)

_____

Approximate number of clients who you have support with self-harm behaviour.

_____

Appendix E

Focus group questions: Exploring the experience of parents whose children self-harm, from a young person's counsellor and wellbeing worker perspective

Welcome the participants and invite them to take a seat, read through the information sheet, and ask any questions they may have. Remind them of the confidentiality agreement. Invite participants to choose their own pseudonym.

Our discussion will focus on the experiences of the parents of children who self-harm

What is the experience of parents when they first find out their children have self-harmed?

What is your experience in how parents find out their children have self-harmed?

What is your experience of how parents respond when they first find their child has self-harmed?

Useful/not useful responses?

Does the experience and/or response of parents change over time?

If yes; is it more or less useful to the young person.

In your experience what proportion of clients want their parents to know about their self harm?

In your experience what portion believes their parents are not aware of their self-harm?

Is there anything specific about the relationship when a young person does or does not want their parents to know about their self-harm?

Do parents see themselves as a source of support for their child?

What would useful support look like from a parent if their child is self harming?

How could professionals best help parents to support their child?

What are the top three things that you think parents should know about self-harm?

Appendix E

Is there anything you want to add that we have not covered in this focus group?

Do you have any questions you would like to ask?

Appendix F

Debrief Sheet

Exploring the experience of parents whose children self-harm, from a young person's counsellor and wellbeing worker perspective

Thank you for taking part in this research project to understand the experiences of parents whose children self harm.

All the information you have provided will remain confidential and completely anonymous, and be handled in accordance with data protection legislation. Your participation in this study is greatly appreciated.

Please feel free to contact us if you have any further questions about this study. Our contact details are provided at the bottom of this page. If you have any concerns about anything which was raised for you in this research, please seek advice from your GP, you may also find the following sources of information helpful:

Helplines:

Mind – Visit the Mind website for supportive and reliable information regarding mental health. Website www.mind.org.uk, phone 0300 123 3393, email info@mind.org.uk

The Samaritans - email: jo@samaritans.org, phone: 116 123

Harmless – Website www.harmless.org.uk/professionals/workingWithYoungPeople

If you have any concerns or questions, please contact us.

Research Team:

Samantha Ruck — Email: 1622346@chester.ac.uk

Dr Hannah Heath (University of Chester) — Email: h.heath@chester.ac.uk

Appendix G

Are you a parent of a child aged 16 plus?

We wish to speak to parents of young people who either have or have not self-harmed

Share your experiences and knowledge in a one to one interview

4 RPS credits available

If you are interested in participating in this study, please contact - Sam Ruck at 1622346@chester.ac.uk

Supervisor Hannah Heath - h.heath@chester.ac.uk

Parents experiences of self-harm<<
Email: 1622346@chester.ac.uk
Supervisor: h.heath@chester.ac.uk

Appendix H

RPS advert

Front page

Available	Study Information	Eligibility
Timeslots available	Young people Self-Harm – A Parents view (4 Credits) Interviews will explore a parent's view of self-harm.	Parents of children over the age of 16

Study Information

Study Name	Young people Self-Harm – A Parents view
Study Type	**Standard (lab) study** This is a standard lab study. To participate, sign up, and go to the specified location at the chosen time.
Credits	4 Credits
Duration	60 minutes
Abstract	Interviews will explore the views and experiences of parents with regards to young people's self-harm.
Description	The interviews will be exploring the views and experiences of parents of children who have and have not self-harmed. The interview will discuss either your experiences of supporting a child who has self-harmed or what process you may expect a parent to go through if their child self-harmed.
Eligibility Requirements	Parents of a child aged 16+. We advise that you do not participate if you have had negative experiences surrounding self-harm or related issues, or if your child has self-harmed recently (within the last 6 months). Please note that the study does not constitute therapy.
Researcher	Samantha Ruck
Principal Investigator	Hannah Heath

Appendix H

Deadlines

Deadlines that occur on a Saturday or Sunday will be moved back to Friday

Sign-Up: 24 hour(s) before the appointment

Cancellation: 24 hour(s) before the appointment

Appendix I

Email response – parents

Young people Self-Harm – A Parents view

Dear (name),

Thank you for expressing your interest in taking part in the study - a parents view on children's self-harm. What will I have to do if I agree to take part?

I will take up no more than one hour of your time. You will be invited to attend a one to one interview. The study will be exploring the views and experiences of parents of children who have and have not self-harmed. The interview will discuss either your experiences of supporting a child who has self-harmed or what process you may expect a parent to go through if their child self-harmed. There will be between 10 and 15 individual interviews running in total. The interviews will discuss a series of questions about self-harm in young people, and your experiences with this.

The interview will be recorded, and later transcribed. All names and places mentioned in the discussion will be anonymised. We will keep your participation in the interview confidential – and people who take part will be given pseudonyms.

You can decide to leave the discussion at any point, but your contributions up to that point may be included in the analysis.

Following the interview, all participants will be given an information sheet containing useful resources for help and support with self-harm.

Please find the attached Information Sheet which will provide you with further details about the research, including the advantages and possible disadvantages of taking part, what the study entails and your rights as a participant.

This study will be speaking to parents of children who have and have not self-harm and therefore the questions regarding your experiences will be different depending on your past experience self-harm. If you decide that you would like to take part, so I can ensure that I complete the correct interview with you, please can you respond to this email with a few convenient times for yourself and which group you fall within?

If you have any queries, concerns or would like some advice regarding whether you should participate or not, you can contact me, by replying to this email.

Thanks and best wishes,

Sam

Appendix J

University of Chester

Participant Information Sheet:

Young people Self-Harm – A Parents view

You are invited to participate in this research study which aims to investigate the experience of parents with relation to young people who self-harm. Please read the following information carefully before deciding whether or not to take part.

What is the purpose of the study?

The purpose of this study is to better understand the experience of self-harm on young people and the experiences of parents, and those who provide support to young people. This study is being complete by a MSc student. No support organisations will receive or have access to any data from the study. The results will be used for a MSc dissertation and it is intended that findings will be used for publication in academic journals and conferences.

Why have I been invited?

You have been invited because you are a parent of a child aged 16+ and have indicated that you are interested in taking part in this research.

Do I have to take part?

Your participation in this study is entirely voluntary. You have the right to leave at any point before or during the study and refrain from answering individual questions. Should you wish to withdraw after completing the study, you have 7 days from the day of interview to do so. Please email me should you wish to do this. Please note that any partially collected data may be used in the analysis unless you formally withdraw your data. Please note that there are no right or wrong answers, and any answers you provide will not be used for diagnostic purposes. If you agree to take part, you will be asked to sign a consent form.

What will I have to do if I agree to take part?

If you agree to take part, you will attend an audio recorded individual interview. You will be asked to discuss either

- - your views on support seeking, and how you might expect a parent to respond to the self-harm of a child over the age of 16
- - or your experiences of being a parent of a child who has, in the past, self-harmed. Including questions regarding your experiences, its impact and the issues it raised for you as a parent trying to support your child.

The interview will last no more than an hour.

What are the possible disadvantages and risks of taking part?

We do not anticipate any disadvantages to taking part. The discussion provides an opportunity to discuss your experiences of what is a difficult topic; sharing experiences can be reassuring. This research covers a sensitive topic and if you feel this will increase your level of distress we advise that you do not participate in the study, or if your child has self-harmed recently (within the last 6 months). Please note that the study does not constitute therapy. The study is for research only and not for diagnostic purposes.

Will I be rewarded for my participation?

Four PRS credits will be rewarded via the PRS system on competition of the interview. In addition we hope that you will enjoy participating in the discussion and contributing to research in an under-explored field. We hope that our findings will result in developing an insight into the issues facing the parents of children who self-harm.

Will my participation in the study be confidential?

Any personally identifiable data collected from you, i.e. the information that you provide in the demographics sheet, will remain confidential. The recordings of the interview will be shared in the research team, and will be stored on a password protected computer. A process of anonymisation during transcription of the recordings will ensure that any identifiable information such as names and locations is removed. The only time we would need to share information was if we were concerned about the safety of a young person, this would be discussed fully with you before any information was shared. If there were significant concerns about the safety of a young person, this information would be shared with Dr Hannah health and the relevant local authority.

It is hoped that the findings will be shared for use in a published academic journal and conferences. Any publication resulting from this work will report only data that does not identify you.

Further information and contact details

If you require any further information about the study, the relevant points of contact are below:

Research Team:

Samantha Ruck Email: 1622346@chester.ac.uk

Dr Hannah Heath (University of Chester) Email: h.heath@chester.ac.uk

If you are affected by any issues raised, you can contact your GP, the Samaritans (email: jo@samaritans.org, phone: 116 123), Family Lives (Website www.familylives.org.uk, phone: 0808 800 2222), Young Minds Parent Helpline (0808 802 5544), Harmless (Website www.harmless.org.uk/whoWeSupport/familyAndFriends)

Any concerns or complaints about the research may be sent to Professor Ros Bramwell, Head of the Department of Psychology, at r.bramwell@chester.ac.uk.

Ethical approval has been provided by the University of Chester Department of Psychology ethics committee

Appendix K

Interview questions: Young people Self-Harm – A Parents view

Parents whose children have self-harmed

Welcome the participant/s and invite them to take a seat, read through the information sheet, and ask any questions they may have. Remind them of the confidentiality agreement. Invite participants to choose their own pseudonym.

Explain that the interview will be discussing their experience linked to their child that has self-harmed.

Please tell me a bit about your family and who's in it?

Please can you tell me about how you found out that your child had self- harmed?

How did you feel when you found out?

What did you do when you found out?

Can you tell me a little bit about what was happening for your child at this point?

Did you seek support from anywhere?

If yes:

At what point did you seek this support?

What was your experience of this support?

Probe: Are there other kinds of support you would like to have been offered?

What support do you think your child wanted at the point you found out they were self-harming?

If no, why was this?

Did your feelings regarding the self-harm change over time?

What are the top three pieces of advice you would give to other parents whose child self-harmed?

Is there anything you want to add that we have not covered in this interview?

Do you have any questions you would like to ask?

Appendix L

Interview questions: Young people Self-Harm – A Parents view

Parents whose children have not self-harmed

Welcome the participant/s and invite them to take a seat, read through the information sheet, and ask any questions they may have. Remind them of the confidentiality agreement. Invite participants to choose their own pseudonym.

Please tell me a bit about your family and who's in it?

Can you tell me what your knowledge of self-harm is, and why a young person might self-harm?

How do you think parents may respond to finding out about their child self-harming?

Would you think that parents would want support if they were to find out their child self-harmed?

Do you know of any support services open to parents?

- If yes, where are these sources of support?
- What would you expect parents to get from this support?
- What support do you think the young person would need if they had self-harmed?

Do you think how a parent would feel or respond over time might change

- If yes; in what way?

What do you think would most help a parent if they were to find out their child had been self-harming?

Is there anything you want to add that we have not covered in this interview?

Do you have any questions you would like to ask?

Appendix M

Consent Form: Young people Self-Harm – A Parents view

Please read the following statements and, if you agree, tick the corresponding box to confirm agreement:

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason by leaving the room.	☐
I understand that my data will be treated confidentially and any publication resulting from this work will report only data that does not identify me. I understand that if I withdraw from the study, any partially collected data will still be used for analysis.	☐
I understand that the research is not in the form of an examination or test and therefore, I should not refrain from expressing myself for fear of being challenged or incorrect.	☐
I understand that the interview will be audio recorded via a Dictaphone.	☐

Name

_____

Signature

_____

Date

_____

Appendix M

Demographics

Your identified gender

_____

Age

_____

Ethnicity

_____

Number of children

_____

Appendix M

Debrief Sheet

Young people Self-Harm – A Parents view

Thank you for taking part in this research project exploring a parents perspective of young peoples self harm.

All the information you have provided will remain confidential and completely anonymous, and be handled in accordance with data protection legislation. Your participation in this study is greatly appreciated.

Please feel free to contact us if you have any further questions about this study. Our contact details are provided at the bottom of this page. If you have any concerns about anything which was raised for you in this research, please seek advice from your GP, you may also find the following sources of information helpful:

Helplines:

Mind – Visit the Mind website for supportive and reliable information regarding mental health. Website www.mind.org.uk, phone 0300 123 3393, email info@mind.org.uk

Samaritan - email: jo@samaritans.org, phone: 116 123

Family Lives (Website www.familylives.org.uk, phone: 0808 800 2222), Young Minds Parent Helpline (0808 802 5544)

Harmless – Website www.harmless.org.uk/professionals/workingWithYoungPeople

If you have any concerns or questions, please contact us.
Research Team:

Samantha Ruck — Email: 1622346@chester.ac.uk

Dr Hannah Heath (University of Chester) — Email: h.heath@chester.ac.uk